EXPERIENCES OF REGISTERED NURSES WHO ENCOUNTER INCIVILITY DURING THE CLINICAL EDUCATION OF NURSING STUDENTS WITHIN HOSPITAL SETTINGS: A PHENOMENOLOGICAL ANALYSIS

by

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ABSTRACT

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Under the direction of SUSAN SWEAT GUNBY, PhD, RN

Incivility is disrespectful and unprofessional behavior consisting of negative attitudes with verbal and physical characteristics which negatively affects registered nurses' work environments and nursing students' clinical education. These behaviors are associated with increased healthcare costs (Joint Commission, 2008), negative patient outcomes, and poor patient satisfaction (Joint Commission, 2008; Randle, 2003). Additionally, incivility occurring during the clinical education of nursing students is a problem that can inhibit learning and communication (Institute of Medicine, 2010; Joint Commission, 2008). Research indicates these behaviors persist on nursing units, creating a challenge for stakeholders in both nursing education and patient care (Academy of Medical-Surgical Nurses, n.d.; Hunt & Marini, 2012; Lucian Leape Institute, 2013). Therefore, this descriptive qualitative study was conducted to explore registered nurses' experiences with incivility during the clinical education of nursing students

within hospital settings in an effort to identify sources and contributing factors of incivility as well as effective strategies to counter incivility in these settings.

A purposive sample of thirteen registered nurses, including staff nurses and clinical faculty, participated in mostly face-to-face, semi-structured interviews. With the support of an integrated conceptual framework utilizing Clark, Olender, Cardoni, and Kenski's (2011) conceptual model for fostering civility in nursing education (adapted for nursing practice) and the reflection-in-action theory by Donald Schön (1983), Giorgi's (1985) descriptive phenomenological method for qualitative research was used to analyze the transcribed verbatim narratives.

Analysis of the data revealed three themes and sixteen subthemes. Themes included influences on uncivil actions, experiencing and responding to incivility, and aftermath of incivility. Stress was an underlying factor within all of the registered nurses' encounters with incivility. Most participants were surprised by the incivility they encountered. Some participants were tearful while others became anxious while describing their experiences.

Findings revealed a need for educating registered nurses, nursing students, and administrators about incivility. Through participants' reflections on their encounters, strategies for addressing incivility were revealed. Recommendations for further study include examining gender differences regarding perceptions of uncivil and civil

behaviors, comparing perpetration of incivility between experienced and less experienced nursing students, and the influence of different levels of nursing education on uncivil actions.

CHAPTER 1

INTRODUCTION TO THE STUDY

This chapter introduces the phenomenon of interest, provides a statement of the problem, and describes the purpose of the study. The research question and conceptual framework used to guide the study are presented. A discussion of the significance of the study, assumptions and biases, and definition of terms used throughout the study conclude this chapter.

Incivility occurring during the clinical education of nursing students is a problem that can inhibit learning and communication (Institute of Medicine, 2010; Joint Commission, 2008). Additionally, incivility occurring between staff nurses and nursing students in clinical education settings may affect the collaborative process that needs to take place in order to provide safe and effective patient-centered care (Anthony & Yastik, 2011). According to the *Code of Ethics for Nurses* (the *Code*), "Collaboration within nursing is essential to address the health of patients and the public effectively" (American Nurses Association [ANA], 2015a, p. 6). Therefore, it is important to identify the sources and contributing factors of incivility as well as effective strategies used to counter incivility in clinical education settings. Armed with this knowledge, stakeholders involved in the clinical education of nursing students, including staff nurses and clinical

educators, can be prepared to address incivility when it is encountered (Luparell, 2011). Reducing and eliminating incivility in clinical education settings will create better learning environments for nursing students and positive work environments for registered nurses, allowing for improved patient outcomes (Anthony & Yastik, 2011; Hunt & Marini, 2012; Luparell, 2011).

Identify the Phenomenon of Interest

Incivility is a form of disruptive behavior occurring in nursing, which is unethical and can ultimately induce negative patient outcomes (ANA, 2015a; Joint Commission, 2008). The *Code* addresses this behavior by explicitly declaring, "Disregard for the effects of one's actions on others, bullying, harassment, intimidation, manipulation, threats, or violence are always morally unacceptable behaviors" (ANA, 2015a, p. 4). Each nurse has a "duty to act to prevent harm" (p. 4) through individual contribution to "an ethical environment and culture of civility" (p. 4) where colleagues and students are treated with respect and dignity (ANA, 2015a). Nurses are instructed to treat all individuals with respect and to "maintain professional, respectful, and caring relationships with colleagues . . . committed to . . . the best resolution of conflicts" (ANA, 2015a, p. 4). Additionally, nurses "seek to achieve safe, quality patient outcomes in all settings . . . providing compassionate, transparent, and effective health services"

(ANA, 2015a, p. 4). By respecting the "values of each person in every professional relationship and setting" (p. 1), nurses support their duty to respect human dignity (ANA, 2015a).

Further, despite a sentinel event alert from the Joint Commission in 2008 that addressed intimidating and disruptive behaviors from healthcare teams, incivility continues to permeate nursing units where uncivil behaviors among nurses in acute care settings have continued (Academy of Medical-Surgical Nurses [AMSN], n.d.; Hunt & Marini, 2012; Lucian Leape Institute, 2013; Luparell, 2011; National Council of State Boards of Nursing [NCSBN], 2011). Uncivil behavior by staff nurses and other members of the healthcare team can lead to medical errors (Institute for Safe Medication Practices [ISMP], 2013; Joint Commission, 2008). Additionally, such uncivil behavior can contribute to poor patient satisfaction and adverse outcomes for patients, increased cost of care, and cause qualified registered nurses, as well as other clinicians, to seek a more professional environment or leave nursing all together (Hutchinson & Jackson, 2015; Joint Commission, 2008; Randle, 2003). A survey examining the effects of disrespectful behavior on safe medication practices in 2013 found this type of behavior not only exists, but "erodes professional communication, which is essential to patient safety and quality" (ISMP, 2013, p.1).

Consequences of these uncivil behaviors, which are occurring in the midst of an increasing nursing shortage, present a challenge for nurse educators and hospital nurse administrators to address incivility in the clinical education setting (Anthony & Yastik,

2011). In response to ethical concerns within nursing education, the National League for Nursing (NLN) published ethical principles applying to all aspects of nursing education to ultimately improve patient care to achieve positive outcomes (NLN, 2012). The quality and safety education for nurses (QSEN) project led to the publication of the knowledge, skills, and attitudes each pre-licensure nursing student should be able to demonstrate in order to increase patient safety (Cronenwett et al., 2007). These QSEN competencies also apply to each licensed registered nurse and should be demonstrated as validation for proficiency "necessary to continuously improve the quality and safety of the healthcare systems in which they work" (Cronenwett et al., 2007, p. 122). Competency of teamwork and collaboration, which includes conflict resolution as one of its essential features, increases communication within the healthcare team to positively affect safety and quality, stifling incivility (Cronenwett et al., 2007).

Purpose of the Study

The purpose of this descriptive phenomenological study was to explore registered nurses' experiences with incivility during the clinical education of nursing students within hospital settings. This exploration included the perceptions registered nurses have of incivility in this context as well as the factors that contributed to their experiences. Additionally, the measures used by registered nurses to prevent or disengage from encounters with incivility during the clinical education of nursing students were investigated. The descriptions of these components will aid in the effort to facilitate a resolution of incivility in clinical education settings.

Research Question

This study addressed one research question: What experiences with incivility have registered nurses encountered during the clinical education of nursing students within hospital settings?

Conceptual Framework

The conceptual framework for this study was composed of Clark, Olender, Cardoni, and Kenski's (2011) conceptual model for fostering civility in nursing education, as adapted for nursing practice and Donald Schön's (1983) reflection-in-action theory. This conceptual framework enabled me to explore the experiences of registered nurses who have encountered incivility during the clinical education of nursing students within hospital settings. These models will be discussed in more detail in the sections that follow.

Conceptual Model for Fostering Civility in Nursing Education as Adapted for Nursing Practice

The first component of my conceptual framework was the model created by Clark and her colleagues (2011), depicted in Appendix A. Their model was selected for this study because it provides an illustration of how a culture of civility or incivility can be created based on how the stress of nursing practice and nursing education is managed. Originally, the conceptual model for fostering civility in nursing education was developed by Clark (2008a) to illustrate how faculty and students contribute to both incivility and civility in nursing education. Clark's (2008a) model was derived from

participant responses to the Incivility in Nursing Education (INE) survey she developed and will be explained later in this chapter. This initial model by Clark (2008a) was adapted by Clark and her colleagues (2011) to incorporate nursing practice. The adapted form depicts the relationship of stressors in both nursing practice and in nursing education that contribute to a high-stress environment (Clark et al., 2011).

Before being adapted to practice, the conceptual model to foster incivility in nursing education was developed from the findings of the INE. This survey tool was developed by Clark in 2004 based on a review of the literature, her professional experience, interviews of nurse educators and nursing students, as well as adaptations from other instruments used to measure classroom incivility in non-nursing environments (Clark, Farnsworth, & Landrum, 2009). Utilizing the INE permits the researcher to gather demographic data and allows participants to select the uncivil behaviors they have encountered over the last 12 months (Clark et al., 2009). Additionally, this survey requests the participants to specify the frequency of their encounters with specific uncivil behaviors (Clark et al., 2009).

The conceptual model to foster civility in nursing education was adapted for nursing practice by the use of Clark's INE survey (Clark et al., 2011). Following a keynote address by one of the investigators in a large western state, the INE was distributed to 174 nurse leaders, consisting of nurse executives and nurse managers. While the sample consisted of nurse executives (39.1%) and nurse managers (60.9%), no staff nurses, nurse educators, or nursing students were included (Clark et al., 2011).

By using the INE to survey these nurse leaders, Clark and her colleagues (2011) found the participants were able to identify the different contributing factors to adverse working relationships between nursing education and nursing practice: (a) the workload of faculty and staff, (b) a lack of communication and collaboration, (c) a lack of mutual curriculum planning between nurse educators and staff, and (d) a lack of adequate human and financial resources (Clark et al., 2011). Differing perceptions among nurse executives and nurse managers were found in regard to these contributing factors. Nurse executives responded (98.53%) that educators contribute to an adverse working relationship by: (a) not staying current with standards and regulations related to nursing practice; (b) a lack of communication and collaboration skills between faculty and staff; (c) a lack of curriculum planning between the nurse educators and the nursing staff; (d) a lack of preceptor engagement due to stress and workload; and (e) a lack of shared vision, mission, and goals between practice and education (Clark et al., 2011). Nurse managers' responses (95.28%) were congruent with nurse executives' identification of nurse faculty not keeping current with nursing practice as contributing to adverse working relationships (Clark et al., 2011). Additionally, nurse managers identified the limited number of faculty was equally contributory, but Clark and her colleagues (2011) did not provide further details about this finding. Finally, high-stress work environments coupled with uncivil behaviors among members of the healthcare team were found to contribute to adverse working relationships (Clark et al., 2011).

Continued survey responses identified strategies that could help foster civility in practice settings (Clark et al., 2011). With response rates of 94.11% and 85.62% respectively, nurse executives and nurse managers suggested strategies to improve civility in the clinical setting: (a) meeting to develop a shared vision and a culture of civility; (b) establishing codes of conduct and policies that clearly outline expected behaviors; (c) educational development regarding conflict resolution, problem solving, and respectful communication; and (d) positive role modeling by all members of the healthcare team (Clark et al., 2011). Nurse managers identified additional strategies of holding oneself and others accountable for acceptable behaviors and to reinforce positive behavior (Clark et al., 2011).

This survey revealed essential skills nursing students need to be prepared to foster civility in the practice setting as (a) conflict resolution, negotiation, assertiveness, and learning to address incivility; (b) effective communication, teamwork, and collaboration; (c) professionalism and leadership skills; and (d) personal accountability and patient safety, as indicated by nurse executives and nurse managers, 89.70% and 93.39% respectively (Clark et al., 2011). Nurse managers additionally reported essential skills for students in the practice setting as (a) time management, organizational skills, decision-making, and problem-solving skills; (b) creating a healthy work environment and organizational culture; (c) civility education; and (d) patient-focused care and safety (Clark et al., 2011).

The final perspective gathered from the INE survey by Clark and her colleagues (2011) focused on the beliefs of nurse executives (85.29%) and nurse managers (79.24%) that nursing education and practice can work together to foster civility in the practice setting. The respondents suggested this could be achieved by (a) improving communication and partnerships between education and practice, (b) developing a shared vision for a culture of civility, (c) integrating civility into the nursing curriculum, (d) fostering leadership and positive role modeling, and (e) teaching civility and behavioral expectations (Clark et al., 2011). Nurse managers additionally included mentoring as well as reinforcing and rewarding civility (Clark et al., 2011).

The conceptual model created by Clark and her colleagues (2011) to foster civility in nursing education, as adapted for nursing practice, illustrates how stress within nursing practice and stress within the clinical education environment can intersect to create a high-stress environment. This can lead to either practice incivility or academic incivility or both (Clark et al., 2011). When remedies, encounters, and opportunities for engagement are missed, avoided, or poorly managed, a culture of incivility is established. Conversely, when remedies, encounters, and opportunities for engagement are seized, implemented, and well-managed, a culture of civility is established (Clark et al., 2011).

Clark and her colleagues (2011) delineated contributing factors to stress in nursing practice: (a) high acuity patients and increased workloads; (b) poor interpersonal relationships, organizational conditions, and volatility; (c) unclear roles

and expectations and imbalance of power; and (d) lack of knowledge and skills in managing conflict. Additionally, contributing factors to stress in nursing education included (a) student entitlement and faculty superiority, (b) demanding workloads and juggling multiple roles, (c) balancing teaching acumen with clinical competence, (d) technology overload, and (e) lack of knowledge and skills in managing conflict (Clark et al., 2011). These researchers found contributing factors to stress are present in encounters with incivility in practice and academia unless remedies, encounters, and opportunities for engagement are seized, implemented, or managed well during the clinical education of nursing students. However, these findings were based on the responses of nurse executives and nurse managers instead of staff nurses, clinical faculty members, and nursing students (Clark et al., 2011).

In their study, Clark and her colleagues (2011) concluded that stress is a major contributing factor to incivility. They recommended gathering suggestions from academic nurse leaders in order to identify ways to foster civility in nursing education and practice (Clark et al., 2011). The contribution of the perspectives of those who directly experienced incivility within clinical education settings strengthened this model and is further discussed in Chapter Four. I could find no additional published studies incorporating this conceptual model. It was determined this newly adapted conceptual model needs further testing. Additionally, no studies incorporating this model to specifically address the occurrence of incivility among nursing students and registered nurses were found.

Reflective Practice

The second component of my conceptual framework was the theory of reflective practice by Donald Schön. Using a study by Inhelder and Karmiloff-Smith, Schön (1983) explained the basis of reflective practice. Schön (1983) noted how the study's authors made verbal descriptions of intuitive understanding through the description of the processes of children's discovery-in-action after being instructed to balance wooden blocks of varying weight on a metal bar. Schön (1983) first described the researchers' observations of the processes children used to complete the task and how they noticed a pattern they described as theory-in-action (Schön, 1983). Theory-in-action described the persistent and universal actions applied to solving the problem and completing the task (Schön, 1983). Some children responded with surprise at being unable to balance the blocks and made a few additional attempts before deeming the blocks impossible to balance. Schön (1983) reported the researchers' observations of the first pattern of response to error as an action-response.

Other children began making corrections and would pause multiple times during these actions to contemplate their previous successful and unsuccessful attempts at balancing the blocks (Schön, 1983). The researchers determined the children held a theory-in-action about balancing the blocks and termed this second pattern of response to error as a theory-response. Schön (1983) summarized the researchers' observations by describing how the children began working through a series of stages to balance the blocks, and when their theories-in-action were unsuccessful, the children stopped to

think about their actions. The children began to methodically correct the blocks using a different strategy, ultimately abandoning their previous theories-in-actions and shifting to a different theory-in-action (Schön, 1983). Schön pointed out how the children shifted from a success orientation to a theory orientation, where positive and negative results become relevant information to a theory of balancing instead of a sign of success or failure in action. The researchers referred to the children's' propensity for developing a feel for the counter-weighted blocks as theories, but Schön (1983) referred to this as a conversion of knowing-in-action to knowledge-in-action. This example provided by Schön (1983) to describe reflection-in-action can assist professionals "to describe a kind of knowing, and a change of knowing, which are probably not originally represented in words at all" (p. 59).

Similarly, the practitioner becomes more expert in practice as more experience is gained (Schön, 1983). The context within which these actions are performed can shape the practitioner's perspective of his or her individual practice. These actions become intuitive within various contexts (Schön, 1983). The practitioner may find difficulty with being able to articulate why or how he or she knows a chosen action will work. Implementing reflective practice can bring this intuitive knowledge to the surface, allowing for its analysis and subsequent growth of knowledge and deeper insight (Schön, 1983).

Schön (1983) described reflection-in-action as thinking while doing; the ability to "think about doing something while doing it" (p. 60), causing an evolution of the current

process. He defined a professional practitioner as a "specialist who encounters certain types of situations again and again" (1983, p. 60). Reflection-in-action can help a practitioner develop professional knowing of intuitive, tacit knowledge (Schön, 1983). Intuitive knowledge is difficult for most practitioners to articulate because it is an internalization of tacit knowledge (Schön, 1983). This type of knowledge not only informs judgments and actions in practice, but it is also evident in a practitioner's actions and is essential for skill acquisition. Intuitive knowledge allows professional practitioners to deal with uncertainty and value conflicts that arise in their professional practice (Schön, 1983).

Despite past reliance on technical rationality, the application of scientific theory and techniques to explain the practice of professionals, intuitive knowledge is not a phenomenon that can be easily quantified (Schön, 1983). This does not mean intuitive knowledge should be ignored. On the contrary, it is a vast resource of new knowledge and professional growth that must be brought to the surface from within the individual practitioner and made known (Schön, 1983).

Reflection-in-action in registered nurses' and nursing students' practice is demonstrated in the context of patient care, the unit which makes up nursing practice and "denotes types of family-resembling examples" (Schön, 1983, p. 60). A nurse's various encounters with patient care allows the "practice" of one's practice (Schön, 1983). This practice allows a nurse to develop a collection of representations of

experiences, such as images, sounds, and smells, thus, decreasing the likelihood of unexpected situations or encounters (Schön, 1983).

Knowing-in-action is the exhibition of ordinary practice knowledge (Schön, 1983). As the practitioner gains clinical experience, knowing-in-action becomes increasingly tacit, spontaneous, and automatic. The monotony of routine practice can lead to a narrowed view where errors and oversights are more likely to occur and important opportunities to think about one's actions can be missed. A practitioner's selective inattention to phenomena that do not fit in one's categories of knowing-in-action can cause the client to incur the consequences of the practitioner's narrow vision and rigidity (Schön, 1983). However, reflection can correct the narrow vision caused by repetitive experiences by surfacing the practitioner's tacit knowledge for critical analysis in order to create a new perspective of uncertain or unique situations (Schön, 1983). Schön's reflection-in-action theory was a valuable piece of the conceptual framework for this study as the tacit knowledge of incivility experienced by the participants during clinical education was discovered from their descriptive accounts.

The multidimensional incivility identification model (MIIM) was evaluated for use in this study. The MIIM was adapted by Hunt and Marini's (2012) analysis of a qualitative study investigating incivility in the practice environment from the perspective of clinical faculty members, of whom 51% had acute care setting experience (Hunt & Marini, 2012). Their model was developed with the goal of showing a conceptual link between incivility and bullying and to also make a "sharper distinction

between the subtypes of incivility along the form and function dimensions" (Hunt & Marini, 2012, p. 367). The MIIM is useful for identifying and describing the types and degrees of incivility and civility as well as providing a continuum to establish the openness or concealment of the behavior, the dimension of function involving the perception of incivility, and the reaction to incivility. Hunt and Marini (2012) believed complexity and interaction between the form and function of incivility could be captured with this model. While their model is useful for identifying and describing uncivil behaviors along continua of form (direct vs. indirect incivility) and function (reactive vs. proactive), it does not account for the different sources or contributing factors of uncivil behavior. For this reason, the Hunt and Marini (2012) model was not selected for this study.

Significance of the Study

Research of incivility in the clinical education setting is growing (Martel, 2015; Thomas, 2015). However, further understanding of incivility regarding preventive strategies, contributing factors, and consequences of these behaviors is needed to prepare nursing students, provide continuing education for staff nurses and clinical faculty, and mitigate negative patient outcomes (Anthony & Yastik, 2011; Clark, 2008a; Clark & Springer, 2007a, 2007b; Daniel, Adams, & Smith, 1994; Jenkins, Kerber, & Woith, 2013). More specifically, Clarke, Kane, Rajacich, and Lafreniere (2012) pointed out the need for exploration of the relationships between clinical faculty, nursing students, and

staff nurses. Moreover, Hunt and Marini (2012) suggested giving an evaluative voice to nursing students and other stakeholders in regard to incivility within clinical settings.

Exploring incivility in clinical education settings is paramount as healthcare is the fastest growing sector in the United States economy, projected to grow 18% by 2026 (Bureau of Labor Statistics, U.S. Department of Labor [Bureau of Labor Statistics], 2018. Currently, registered nurses comprise 2.9 million jobs in the healthcare sector (Bureau of Labor Statistics, 2018). In 2016, 61% of 3 million registered nurses were employed in hospitals in the United States and are the largest healthcare occupation in the United States (Bureau of Labor Statistics, 2018). Survey results published in the NCSBN's Environmental Scan (2016) reported 58.1% of registered nurses identified as "staff nurse."

Globally, there is a healthcare crisis due to a shortage of professional healthcare workers. Among the reasons for this crisis are unhealthy work environments amid poor organizational climates (International Council of Nurses [ICN], 2008). The American Nurses Association (2014) endorsed the description of a healthy work environment from both the American Association of Colleges of Nursing and the World Health Organization as one that promotes optimal health and safety by being "safe, empowering, and satisfying;" as well as a place of "physical, mental, and social well-being" (ANA, 2014, Healthy Work Environment section, para. 1). A healthy work environment includes creating a culture of safety where each health team member is patient-centered and performs with professionalism and accountability in which all healthcare workers

"provide a sense of safety, respect and empowerment to and for all persons" (ANA, 2014, Healthy Work Environment section, para. 1). After all, "disrespectful treatment of workers increases the risk of patient injury" (Lucian Leape Institute, 2013, p. ES2).

Retaining nurses is vital as the nursing shortage looms in the United States. Nursing practiced in a civil culture with mutual respect can lead to nurse retention and collegiality which also increases the quality of patient care and patient safety (Lucian Leap Institute, 2013). This crucial tenet is more likely to be achieved with "the basic precondition of a safe workplace . . . protection of the physical and psychological safety of the workforce" (Lucian Leape Institute, 2013, p. 6). Despite studies on incivility over the past 20 years, healthcare workers today are as likely to be treated with disrespect as they were ten years ago (Lucian Leape Institute, 2013). "Establishing positive practice environments across health sectors worldwide is of paramount importance if patient safety and health workers' well-being are to be guaranteed" (ICN, 2008, p. 1).

The National Council of State Boards of Nursing, National League for Nursing, American Nurses Association, and the Academy of Medical-Surgical Nurses, along with the Joint Commission, have recognized the problem of incivility in healthcare goes beyond individuals engaging in this disruptive behavior and they delineate its effects on patient safety and quality healthcare outcomes. The Joint Commission (2008), recognizing that physician and non-physician staff are engaging in intimidating and disruptive behaviors, issued a sentinel event alert effective January 2009. This alert called for organizations to institute a code of conduct outlining intimidating and

disruptive behaviors and for the establishment of a zero-tolerance policy as the consequence for these behaviors (Joint Commission, 2008). This followed a previously released set of guidelines in 2004 from the Occupational Safety and Health Administration (OSHA) that focused on the prevention of workplace violence. Healthcare professionals remain a significant risk for workplace violence in the United States as "10.2% of all workplace violence" (p. 3) occurs in medical occupations (OSHA, 2015). The number of actual occurrences is likely to be higher because most workplace violence goes unreported (OSHA, 2015).

More recently, the National Council of State Boards of Nursing (NCSBN) (2011) issued a white paper regarding nurses' use of social media. Within this document, the NCSBN (2011) acknowledged the occurrence of lateral violence that occurs among nurses whether in person or via the Internet. They described how disruptive behaviors among nurses reduce the cohesiveness of healthcare teams, ultimately affecting patient care and quality clinical outcomes. As a result, nurses are subject to sanctions by the boards of nursing for comments perceived as threatening, whether communicated in person or via the Internet. The ANA, Academy of Medical-Surgical Nurses, and the American Association of Critical Care Nurses are among the professional nursing organizations that have also addressed incivility in the healthcare arena (AACN, 2016; AMSN, 2012; ANA, 2006, 2014, 2015b).

Despite efforts from these healthcare and professional nursing agencies, the results from the ISMP (2013) workplace violence survey revealed incivility persists in

healthcare settings. Thus, the healthcare setting becomes an educational environment for nursing students to not only learn how to apply the nursing process in actual patient care, but to also, unfortunately, be introduced to intimidating and disruptive workplace behaviors. Following graduation, when students become professional nurses and experience uncivil behaviors in the workplace, their experiences may go unreported due to feeling a lack of administrative support or they may exhibit uncivil behaviors in order to survive in a hostile environment (Joint Commission, 2008; Randle, 2003), thus perpetuating a cycle of incivility which Clark (2008a) referred to as a "dance of incivility" (p. E37). Therefore, it is important to conduct studies like this one in order to address this critical issue.

Assumptions and Biases

Assumptions and biases within a qualitative study are important to identify in order for the consumer of the research to have confidence and trust in the study's findings. Assumptions are principles held to be true, as no proof can be offered for their support (Polit & Beck, 2012). Study results can be influenced from biases in many areas and can undermine the validity of the findings (Polit & Beck, 2012). Therefore, my assumptions and biases for this study are discussed.

My first assumption was in regard to the registered nurses who would participate in this study. I assumed they actually experienced incivility with nursing students who

were present for clinical education in hospital settings. This was important to establish because those who have experienced the phenomenon of interest are the best individuals to describe it (Polit & Beck, 2012).

My second assumption was the participants would not be able to recall the educational background nursing students with whom incivility was experienced. Students may be enrolled in different kinds of nursing programs leading to a degree or diploma. The different types of nursing programs can include (a) licensed practical/vocational, (b) nursing diploma, (c) associate degree in nursing, (d) prelicensure baccalaureate nursing degree, or (e) registered nurse (RN) to bachelor of science in nursing degree. Finally, nursing students may also be enrolled in a second-degree nursing program, where nursing is the second degree being earned by the nursing student.

My third assumption was incivility occurring during clinical education could hinder patient care and outcomes. Therefore, I assume a caring clinical environment must be established and students should feel supported by not only their faculty, but also staff nurses and other members of the healthcare team. Furthermore, my beliefs are congruent with reports from Luparell (2011) and Randle (2003) who noted nursing students repeatedly exposed to uncivil behaviors may eventually incorporate these behaviors in their own nursing practice.

My fourth assumption was both staff nurses and nursing students have the propensity to instigate incivility toward one another, particularly if either is experiencing

stress. I believe staff nurses who are experiencing organizational stress stemming from short-staffing and high-acuity patient loads may consider having a nursing student assigned to work with them as an additional stressor. Similarly, nursing students may experience stress from participating in their initial clinical experience, being unfamiliar about a patient's current health condition, or being aware of the evaluation of the clinical faculty.

Finally, I have additional assumptions that have formed from previous uncivil behavior of staff nurses toward nursing students. First, I assume some staff nurses have not read a current edition of the *Code of Ethics for Nurses* (the *Code*) and are thereby unfamiliar with the standards established for the practice of professional nursing. Second, I assume some staff nurses may be familiar with the content of the *Code* but may not be proficient in the practical application of these ethical standards. Third, I assume some staff nurses may be aware of the specific content areas of the *Code* but have no interest in maintaining the professional standard of nursing practice as delineated in the *Code* or may be selective in the standards they choose to apply to their individual practice. It is appalling that incivility continues to be an issue for nursing education and healthcare agencies around the world in light of the published evidence of its effects. Disruptive behaviors are a direct violation of the *Code of Ethics for Nurses* that can lead to the creation of negative, unethical environments (ANA, 2015a; Lachman, 2014).

Bias can occur from the participants, the study design, or the researcher. The setting in which participants respond to interview questions can influence their perceived freedom to respond. Furthermore, participants can experience difficulty in conveying their experience with incivility openly and honestly. To mitigate these occurrences, the researcher allowed participants to respond to interview questions in mutually selected private settings (Polit & Beck, 2012).

I used the process of reflexivity to guard against inserting personal bias into the study results by making note of personal values and opinions that could have affected data collection and interpretation as suggested by Polit and Beck (2012). I was initially interested in the phenomenon of incivility occurring during clinical education when nursing students, enrolled at my institution, reported experiencing behaviors of staff nurses and clinical instructors deemed uncivil. Therefore, these anecdotal reports were bracketed during the processes of data gathering and analysis.

Reports I received from nursing students regarding their encounters with incivility from staff nurses created my personal bias toward the belief that staff nurses perpetrate incivility toward nursing students. Conversely, due to interactions with nursing students as a nurse educator and from sources identified in the literature review, I believe some nursing students do not realize their behaviors or attitudes can be perceived as rude or entitled, resulting in staff nurses responding defensively in a manner perceived as uncivil by nursing students. To counter researcher bias, I strived to

'unknow' preconceived knowledge of my encounters in clinical settings and from the research conducted for this study (Munhall, 2012).

Definitions of Terms

The following terms are relevant to this study and are defined in this section.

Bullying is a pervasive and harmful phenomenon characterized by deliberate, repeated behaviors, which may be subtle and masked, intended to harm others and to create a hostile environment (Hutchinson, Vickers, Jackson, & Wilkes, 2006).

Clinical Faculty/Instructors supervise nursing students within clinical education settings in order to evaluate nursing students' performance of nursing skills and care.

Clinical Education is nursing education that takes place in hospital settings, such as medical-surgical units, whereby nursing students apply theory in practice in the form of direct patient care while being supervised by clinical faculty.

Civility is "an authentic respect for others when expressing disagreement, disparity, or controversy . . . requiring . . . time, presence, a willingness to engage in genuine discourse, and a sincere intention to seek common ground" (Clark & Carnosso, 2008, p. 13).

Culture of Civility refers to an environment where individuals respectfully interact with effective communication and active engagement through the appreciation of one another's contributions and by actively listening (Clark, 2008a).

Culture of Incivility results from high-stress environments where individuals disrespectfully interact by presenting attitudes of superiority and entitlement, avoiding opportunities for engagement (Clark, 2008a).

Entitlement is a mentality of consumerism where students desire due consideration, convenience, and a low-cost, high-quality education (Clark, 2008a).

Incivility is "rude or disruptive behaviors which often result in psychological or physiological distress for the people involved, and if left unaddressed may progress into threatening situations" (Clark et al., 2009, p. 7).

Medical-Surgical Unit is an acute care setting in which registered nurses and other healthcare professionals provide "short-term inpatient stabilization" (Retrieved from http://www.who.int/bulletin/volumes/91/5/12-112664/en/, para 4).

Nursing Student is a student enrolled in any type of nursing program who is present in the clinical education setting to accrue clinical hours required to fulfill requirements for a nursing degree.

Preceptor is a staff nurse employed by a healthcare facility who agrees to evaluate an individual nursing student from a school of nursing. This preceptor evaluates each student's ability to perform and function as a competent nurse, usually as a service to the nursing profession with no monetary compensation.

Reflection-in-Action is a process of thinking about something while in the midst of a performance by focusing "interactively on the outcomes of the action, the action itself, and the intuitive knowing implicit in the action" (Schön, 1983, p. 56).

Staff Nurse is a full-time staff nurse with at least 2 years of nursing experience who works exclusively on an acute care nursing unit caring for patients' acute or chronic medical or surgical problems.

Stress, as experienced by nursing students, stemming from demanding workloads, juggling multiple roles, competing in a high-stakes academic environment, and clinical practice, such as lack of experience, fear of making mistakes, or harming a patient, as well as concern about faculty evaluation of clinical performance (Clark, 2008a). Accounts of stress experienced by staff nurses are related to demanding workloads, negative work environments, and feeling a lack of support from management (Hutchinson & Jackson, 2015).

Tacit Knowledge is "knowledge we cannot put into words" (Polanyi, 1966, p. 4).

Uncivil is speech or actions that are disrespectful or rude and range from insulting remarks and verbal abuse to explosive, violent behavior (Clark & Springer, 2007b).

Verbal Abuse is a disruptive behavior in the form of verbal communication "associated with horizontal violence and bullying" (Center for American Nurses, 2008, p. 2).

Vertical Violence is described as abusive behaviors in the workplace from a person in a superior position (staff nurse) directed to a person in a subordinate position (nursing student) (Thomas & Burk, 2009).

Workplace Violence is defined by the National Institute for Occupational Safety and Health (2016) as "any physical assault, threatening behavior, or verbal abuse occurring in the workplace . . . including . . . overt and covert behaviors ranging in aggressiveness from verbal harassment to murder."

Summary

This chapter introduced the phenomenon of interest and the problem statement. The research questions and conceptual framework were presented. The significance of the problem and assumptions and biases were discussed. Definitions of terms that were used in this study concluded this chapter.

CHAPTER 2

REVIEW OF LITERATURE

This review of literature will begin by discussing the context of incivility in clinical education settings. The conceptual framework will be outlined to show how it was used in this study. A synthesis of the relevant literature related to the phenomenon of interest is presented and highlighted by themes found within the published research. Inferences for my study will conclude the chapter.

Context of Current Study

Incivility, as defined by Clark et al. (2009), can result in psychological or physiological distress for those experiencing this phenomenon. Additionally, incivility can be experienced in various environments within nursing education. Academic incivility in nursing education can occur in the classroom, online, and in the clinical setting (Suplee, Lachman, Siebert, & Anselmi, 2008). These behaviors can take place between students, students and faculty, faculty members, as well as administrators and faculty (Luparell, 2004; Suplee et al., 2008). In the clinical education environment, uncivil encounters involving nursing students can occur with staff nurses or clinical faculty.

Incivility in Clinical Education

Clinical education is intended to provide opportunities for nursing students to apply theoretical knowledge learned in didactic nursing education within healthcare settings. The majority of clinical education takes place in acute care settings, including medical-surgical units. To maintain safety for both the nursing students and patients, nursing students require supervision by either a clinical instructor of a school of nursing or a preceptor employed by a hospital facility. Under this supervision, nursing students provide basic nursing care such as bathing and changing bed linens as well as more advanced procedures such as administering medications. As this literature review revealed, incivility in the clinical education setting can cause nursing students to miss learning opportunities and potentially perpetuate uncivil behaviors as registered nurses.

Incivility is a type of disruptive behavior known to cause negative effects for the nursing profession, nursing education, and patients. Luparell (2011) discussed the damaging effects of incivility nurse faculty received from nursing students after providing negative evaluations of clinical skills, exams, and overall course grades. She noted individuals may be prone to disruptive behaviors, thereby supporting the need for screening of potential nursing students for these types of behaviors during the admission process for nursing education (Luparell, 2011).

During their clinical education in uncivil healthcare environments, nursing students have become targets of workplace violence (Anthony & Yastik, 2011; Anthony,

Yastik, MacDonald & Marshall, 2014; Hutcheson & Lux, 2011; Martel, 2015; Thomas, 2015; Thomas & Burk, 2009; Thomas, Jinks, & Jack, 2015). Equally disturbing, students who have witnessed or have been exposed to these behaviors during their socialization into the nursing profession can potentially incorporate them into their practice as professional nurses, perpetuating the cycle of violence (Martel, 2015; Thomas et al., 2015). Frequent exposure to these disruptive behaviors can create a sense that these dangerous, unethical behaviors are normal interactions within healthcare settings and in the nursing profession (Luparell, 2011).

In clinical education settings, collaboration and communication are essential components that can ensure safe nursing practice, decrease missed learning opportunities, and prevent errors in the delivery of patient care (Altmiller, 2012; ISMP, 2013; Thomas, 2015). In the presence of incivility, both collaboration and communication can fail (Felblinger, 2008). Uncivil behaviors lead to a culture of incivility in the clinical education setting through intimidation and displays of disruptive behaviors (Clark et al., 2011). Nursing students can learn both civil and uncivil behaviors from staff nurses while they are present on a clinical unit (Anthony & Yastik, 2011; Luparell, 2011). Being referred back to their instructors as well as encountering sarcastic remarks and other uncivil behaviors from staff nurses can cause reluctance when nursing students need to communicate with these nurses, causing gaps in communication that can lead to patient harm (Anthony & Yastik, 2011; Spence Laschinger, 2014). Conversely, a positive learning environment created by civil,

welcoming, and caring staff nurses has been shown to increase nursing students' opportunities for learning while decreasing the perpetuation of incivility (Anthony & Yastik, 2011; Birx & Baldwin, 2002; Levett-Jones, Lathlean, Higgins, & McMillan, 2009; Vallant & Neville, 2006).

The published evidence of the effects of incivility in both nursing education and healthcare agencies is a global concern. Disruptive behaviors are a direct violation of the *Code of Ethics for Nurses* that can lead to the creation of negative, unethical environments (ANA, 2015a; Lachman, 2014). These environments breed a culture of incivility that have been shown to decrease student learning during clinical education and put patients' safety and quality of care at risk (ISMP, 2013; Joint Commission, 2008; Thomas, 2015; Thomas et al., 2015). The International Council for Nurses (2007) emphasized bullying behaviors in the workplace lead to "poor professional practice environments" (p. 1) that harm patients, negatively affect nurse retention and nurse recruitment, and cause a decline in quality patient care. Nurse educators have an ethical obligation to "promote and maintain optimal standards of education and practice in every setting where learning activities occur . . . ensuring that all of their graduates possess the knowledge, skills, and moral dispositions that are essential to nursing" (ANA, 2015a, p. 28) which can hopefully curb the supply of uncivil nurse graduates available for employment in healthcare agencies. Additionally, nurse educators can increase the likelihood of sending nurse graduates into civil and healthy work environments through collaboration with healthcare agencies.

Historical

Early studies of nursing education examined relationships between staff nurses and nursing students as well as nursing students' involvement in unethical behaviors in the classroom and clinical settings. Without a methodological design or support from data, Amann and Williams (1960) presented public health nurses' thoughts expressed during a meeting informing them of incoming nursing students for which they would provide two weeks of education. Their responses revealed a dichotomy of positive and negative attitudes toward working with students. Amann & Williams (1960) concluded that during clinical experiences, nurses and students learn about and from each other.

Hilbert (1985) used quantitative methods to elicit responses from senior nursing students less than one month away from graduation regarding their opinions and experiences of unethical nursing behaviors. She found that unethical classroom behaviors had a significant relationship with unethical clinical behaviors (1985). Additionally, students' opinions about what constitutes unethical behaviors differed from faculty opinions, including taking medications and hospital equipment home for personal use (Hilbert, 1985). Nursing students admitted they ate patients' food, falsified documentation, and an alarming 4% of nursing students admitted they had attended clinical while under the influence of drugs or alcohol (Hilbert, 1985).

Studies focusing on disruptive behaviors in nursing education were relatively scarce before Lashley & De Meneses (2001) published a landmark quantitative study of 409 nursing programs in the United States. They sought to identify the extent of uncivil

behaviors occurring in nursing programs (2001). With an astonishing 67% response rate from nursing administrators, the investigators found nursing programs with greater than 200 students in their public institutions had clinical faculty and student peers who experienced verbal abuse within the clinical setting.

Luparell (2004) followed with a qualitative study of 21 nurse faculty to explore their descriptions of nursing student incivility and its effects. Faculty described students who displayed rude behavior toward patients' families, documented nursing care that was actually completed by the registered nurse, and documented patient care that was not actually performed (Luparell, 2004). Uncivil student behaviors were described as "disrespectful, sarcastic retorts," displaying "indignation toward faculty," and non-verbal and verbal aggression, such as "foul language . . . intimidation, and sometimes direct threats to personal safety" (p. 63). These findings raised concern for how students with no restraint of uncivil behaviors in the presence of power and authority, such as nursing faculty, would conduct themselves among their nurse colleagues and, especially, patients (Luparell, 2004).

Clark and Springer (2007a, 2007b) continued the discussion of incivility in nursing education by focusing mostly on the uncivil interactions between nursing faculty and nursing students in the classroom. They developed the Incivility in Nursing Education (INE) survey to measure nursing faculty and nursing students' perceptions of incivility in nursing education (2007a, 2007b). Using the INE survey, Clark and Springer (2007a, 2007b) found possible causes of classroom incivility to be student disinterest as well as

high-stress environments that were lacking in professionalism and respect. Clark and Springer's (2007b) report of the qualitative thread of their study described the lack of student preparation as a possible cause of incivility, supporting Lashley and De Meneses' finding from 2001.

These studies illuminated the surprising problem of uncivil and unethical practices within the nursing profession, occurring before nursing students graduated to become practicing nurses. The synthesis of the review of literature for the current study includes sources illustrating how incivility continues today despite recommended strategies and published evidence of its consequences. A gap in the nursing education literature regarding the reasons why incivility continues to plague acute care settings required further investigation through interviews with registered nurses.

Experiential

As a clinical instructor, I received complaints from nursing students who were unable to perform patient care due to conflicts with staff nurses. On one occasion a student in her first medical-surgical clinical had an opportunity to give medications. The student's attempt to collaborate with the nurse regarding medication administration was met with hostility, ultimately resulting in the student being unable to administer the patient's medications. I began to notice the nurse had a similar attitude with other students assigned to care for patients with her. Ultimately, I discussed the issue with the charge nurse, but I did not receive support.

On the clinical education unit, staff nurses communicated the lack of interest some nursing students appeared to have regarding patient care opportunities. More specifically, I received a telephone call from a staff nurse, who was employed on a nursing unit to which I had assigned a nursing student for repetitive practice of a nursing skill. The nurse reported the nursing student was leaning over on the desk with her head down, appearing to be asleep.

Overview of Literature Review About Conceptual Framework

The theoretical basis for this study combined Clark and colleagues' (2011) conceptual model for fostering civility in nursing education, as adapted for nursing practice, and Schön's (1983) reflection-in-action theory to guide the research process. The reflection-in-action theory provided the foundation for exploring registered nurses' encounters with incivility during the clinical education of nursing students in hospital settings. This study used Clark and colleagues' (2011) model to identify what registered nurses perceived as contributing factors to uncivil encounters with nursing students and clinical faculty and to determine what can be done to prevent or disengage from these encounters.

Reflection-in-Practice Theory

This theory explains how practitioners develop tacit knowledge in their professional practice, which is evidenced by the solutions that result from problems that are actively reframed, based on their past experiences in similar situations (Schön, 1983). This reflection occurs in the midst of their practice and is known as the artistry of

their practice (Schön, 1983). Before practitioners can develop tacit knowledge, they rely on technical rationality, which refers to the use of theories or guidelines to solve problems (Schön, 1983) and are concerned with empirical laws (Powell, 1989). Over time a repetitive approach applied to similar situations develops a tacit knowledge within the individual (Polanyi, 1966; Schön, 1983). This type of tacit knowledge is difficult for most practitioners to explain, requiring qualitative methods to help the researcher elucidate the hidden knowledge practitioners possess. Stockhausen (2006) explained that reflection-in-action creates intuitive knowledge, "a tacit body of knowledge" that is difficult to capture, given its elusive nature (p. 57) and must be "mined" (p. 57) from the head of the practitioner.

Reflection-in-action has been described as responding to an unexpected practical experience with a combination of drawing on past experiences with theoretical knowledge use (Powell, 1989; Stockhausen, 2006). Powell (1989) noted two key features of reflection-in-action, the first feature being "flexibility and experimentation" (p. 825). This feature involves actively trying to solve a problem whose solution may result in unexpected changes. The second feature involved taking past solutions to problems and individualizing them to current problems (Powell, 1989). A practitioner gains intuitive knowledge by reflecting on these types of experiences in practice which can be effective for solving problems in both the present and the future (Powell, 1989; Stockhausen, 2006). If one does not learn from practice no change will occur, perpetuating the problem, resulting in stagnant nursing practice (Powell, 1989).

Reflection-in-action theory has been applied in different studies of nursing practice. Powell (1989) noticed that nursing students learned more from nurses who had become expert practitioners as opposed to nurses who had just as much experience but lacked expert practice. Using an ethnographic approach with the application of Schön's theory, Powell (1989) examined the practice of eight registered nurses by observing their behavior in practice followed with unstructured interviews with each nurse. She found nurses who approached problems using actions based on no value, ultimately found a helpful solution, but caused the nurse to consume valuable time (1989). Using this sort of technical rationality may be enforced by prescriptive practice and reinforced by the work environment, making practice difficult to change (Powell, 1989). Although both technical rationality and reflection-in-practice require extensive knowledge, Powell (1989) found that reflection-in-action is most effective for finding a solution.

Similarly, Stockhausen (2006) wanted to know how experienced practitioners taught nursing students during structured clinical placements. She observed the interactions of 11 registered nurses in acute care settings in a large metropolitan hospital with 40 undergraduate students from three universities over a period of months. Like Powell (1989), she noted key features that must be present in order for reflection-in-action to take place: (a) reflection, (b) experience, and (c) being in the moment as it unfolds. Occurrences of missed opportunities for learning by either the registered nurses or the nursing students were observed by Stockhausen (2006). These

occurrences were illustrated by the nurse not realizing he or she was relying on reflection-in-action during patient care and the student being distracted from the nurse's interaction with the patient.

Stockhausen (2006) used the term métier artistry, the tacit knowledge gained through the experience of one who excels in his or her occupation, to describe the authentic, reflective, situated practice of expert nurses. She noted how this type of knowledge "accrues over time, through experience, and is unconsciously modelled *[sic]* to students" (p. 58) in a subtle and unique way during the nurses' routine practice (Stockhausen, 2006). Likewise, nursing students who are exposed to the "deep, intrinsic professional artistry of practitioners" (p. 60) will "serendipitously model 'being a nurse'" (p. 58). In Stockhausen's (2006) study, learning and teaching occurred through the actions of the nurse within the context of the moment even though the nurses could not verbally model their thought process.

Therefore, reflection-in-action that is witnessed can go unnoticed because the participants are unaware of the potential teaching or learning event occurring during the artistry of practice (Stockhausen, 2006). In relation to nursing, reflection-in-action is demonstrated by the nurse who responds spontaneously to a situation by drawing on previously learned patterns of knowing and information alerts that enable appropriate action. However, the observer may either be distracted or unaware of the significance of this response due to inexperience, potentially causing an altered interpretation of behavior or cause one to miss cues (Stockhausen, 2006).

Conceptual Model for Fostering Civility in Nursing Education as Adapted for Nursing Practice

Before this model was adapted for nursing practice, Clark (2008a) illustrated how incivility develops in nursing education between a nurse faculty and a nursing student. Both models depict how the attitudes of two people in different roles, who are experiencing high levels of stress, miss opportunities of engagement that result in a culture of incivility (Clark, 2008a; Clark et al., 2011). The adapted model used in my study outlines contributing factors to the stress experienced in nursing practice and in nursing education (see Appendix A). When a high-stressed staff nurse and a high-stressed nursing student encounter one another two possible outcomes can occur, depending on how the encounter is handled. Poorly managed or missed opportunities, remedies, and engagements result in a culture of incivility. However, if the opportunities, remedies, and engagements are seized, implemented, and well-managed, then a culture of civility will result (Clark et al., 2011).

According to this model, a reduction of incivility can occur when either the staff nurse or the nursing student or both have reduced stress or if their interaction can be well-managed despite the stress (Clark et al., 2011). It may not be realistic to expect the staff nurse and the nursing student to avoid interaction until the stress resolves. Patient care must be a priority, but it is important that these two individuals implement strategies, remedies, or manage the encounter well to avoid a culture of incivility.

During the literature search, no studies incorporating Clark and colleagues' (2011) conceptual model were found; however, their model was used in the context of this study as a guide to formulate the interview questions regarding the contributing factors to incivility and what actions were taken to prevent or disengage from the encounter. Additionally, their model provided the lens through which the participants' responses were examined and later described after the data analysis was concluded (2011). A description of what it was like for registered nurses in hospital settings to encounter incivility during the clinical education of nursing students resulted.

The primary aim of this study was to facilitate the resolution of incivility in clinical education settings. Within the context of this study, registered nurses working in hospital settings were interviewed to explore their encounters with incivility during the clinical education of nursing students. The conceptual framework of this study utilized Schön's (1983) reflection-in-action theory and Clark and colleagues' (2011) conceptual model for fostering civility in nursing education, as adapted for nursing practice, to guide data collection and the analysis of the descriptions provided by the registered nurses. Presenting these data to stakeholders of nursing education and the nursing profession will empower them to combat this dangerous phenomenon, thereby creating a safer environment for patients to receive care, for nurses to practice, and for nursing students to learn.

Philosophical Underpinnings

Husserl's descriptive phenomenological approach was used in this qualitative study to explore the experiences of registered nurses who encountered incivility during the clinical education of nursing students. The analysis of the descriptive narratives provided by registered nurses unearthed the essence of what it is like to experience this phenomenon. Having an understanding of incivility in this context can help resolve the occurrence of this threatening phenomenon by contributing support for changes within the nursing profession and nursing education while also creating a foundation for further empirical study.

Husserl (1931/1962) described pure phenomenology as an approach used to view purified phenomena occurring in everyday life as they are presented before a person in a psychological experience. He further described how phenomenological reduction, a method of setting aside a person's limitations of a priori knowledge, is used to enhance the view of purified phenomena. Giorgi (1985) explained descriptive phenomenology seeks to describe a phenomenon using rich descriptions from individuals who have actually lived through the experience. Hence, "sciences of experience are sciences of 'fact'" (p. 46), providing insight into the essence of a phenomenon (Husserl, 1931/1962). Therefore, registered nurses who have lived through experiences with incivility they encountered with nursing students during clinical education were asked to provide concrete descriptions of these events.

The datum of pure essence is contained in the descriptions provided by those who have experienced the phenomenon (Husserl, 1931/1962; Moustakas, 1994). "Every description of an essence is a norm for empirical existence" (Husserl, 1931/1962, p. 407). Therefore, the researcher uses phenomenological reduction while dwelling within these rich descriptions in an effort to gain essential insight of what it is like to experience the phenomenon (Giorgi, 2009).

Essential insight is "independent of knowledge of facts" (Husserl 1931/1962, p. 407). Throughout the data collection and analysis of a descriptive phenomenological study, the researcher must use bracketing in order to describe the pure essence of a phenomenon. Bracketing requires a researcher to set aside judgments and disconnect from any convictions that could interfere with identifying the essence of a phenomenon (Husserl 1931/1962). Therefore, throughout the data collection and analysis of this study, I bracketed my opinions and judgments emanating from experiences with incivility both personally and as described by staff nurses as well as clinical students assigned to me.

Synthesis of Literature

A comprehensive review of the literature was performed to locate articles using qualitative, quantitative studies, and mixed research methods pertaining to staff nurses' experiences with incivility during the clinical education of nursing students. Incivility during the clinical education of nursing students has been explored, but most of this

research is from the nursing students' perspective. A concerning discovery was finding no published research of staff nurses' experiences with this phenomenon.

The literature search was conducted mostly through Mercer University's online library, utilizing Cumulative Index to Nursing and Allied Health Literature, PubMed, Academic Search Complete, Ovid, and Web of Science databases. The primary keywords used to search these databases included incivility, staff nurses, nursing students, and clinical education. Studies relevant to the phenomenon of interest were selected for this review and were published between 1960 and 2018.

Clinical education has been studied in an effort to develop an understanding of nursing student perceptions of violence in the clinical setting, including workplace violence, vertical violence, and incivility. A small number of studies (Anthony & Yastik, 2011; Anthony, Yastik, MacDonald, & Marshall, 2014; Martel, 2015; Thomas, 2015; & Thomas, Jinks, & Jack, 2015) were found to have directly explored the phenomenon of incivility between staff nurses and nursing students occurring during clinical education. Most of these studies (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; & Thomas et al., 2015) used qualitative methods to explore nursing students' experiences with the phenomenon of interest. Two of these qualitative studies were published as doctoral dissertations by Martel (2015) and Thomas (2015).

Although student perspectives are essential in solving the problem of incivility in clinical education, staff nurses need an opportunity to voice their experiences to provide a more comprehensive understanding of this phenomenon. Gaining insight to staff

nurses' experiences and perceptions as well as identifying useful ways they disengage from incivility in this context are essential to solving a problem that contributes to poor quality patient care, jeopardizes patient safety, and creates both an unhealthy work and learning environment (AACN, 2016; ANA, 2015b; Joint Commission, 2008; Luparell, 2011). Gaps in the literature were found pertaining to staff nurses' experiences of incivility during the clinical education of nursing students, the contributing factors to incivility perceived by staff nurses, and the types of strategies staff nurses have used to prevent or disengage from uncivil interactions during clinical education. The following sections will present what I found in the literature regarding the phenomenon of interest and will identify the gaps found as a result of the literature review.

Experiences With Incivility During Clinical Education of Nursing Students

The phenomenon of incivility during clinical education with nursing students as experienced by staff nurses can only be inferred from research that has provided nursing students' and clinical faculty members' perspectives of the phenomenon of interest as no descriptive studies of staff nurses' experiences were found. As a result, the reviewed literature had to be expanded to include phenomena other than incivility in order to provide a more comprehensive state of the science regarding the phenomenon under investigation. Therefore, the following sections will include studies examining staff nurse and nursing student relationships as well as nursing students' experiences with incivility and vertical violence in clinical settings.

Staff nurses' attitudes regarding nursing students. Amann and Williams (1960), without methodological or data support, presented thoughts expressed by public health nurses who were charged with introducing students to the public health field over a two-week period. The nurses expressed surprise that it was time for a new group of students to join them, prompting them to reveal both positive and negative attitudes regarding the presence of nursing students (Amann & Williams, 1960). Negativity stemmed from the nurses having to rearrange their personal leave time as well as the time consumed by teaching students. Nurses with positive attitudes rebutted that at one time someone had to teach them and that they looked forward to the time students could spend with the patients (Amann & Williams, 1960). Further, having the nursing students during the two-week period resulted in the nurses being alert to new knowledge the nursing students brought to them. Likewise, the students observed and learned from the clinical abilities of the nurses, leading Amann and Williams (1960) to conclude staff nurses and nursing students learn about and from each other during clinical experiences.

This phenomenon was further investigated by Matsumura, Callister, Palmer, Cox, and Larsen (2004), who conducted a multi-site mixed methods study of 165 staff nurses in the western United States. They found nurses had ambivalent feelings about working with students. Although nurses experienced fulfillment of mentoring students and that students could lighten the work load, some felt their professional security was threatened and expressed frustration related to working with "problem students" (p.

298). Similar to Amann and William's (1960) study, Jackson and Neighbors' (1988) quantitative study of 57 staff nurses found nurses had a less favorable attitude toward nursing students than other aspects of their work environment. These studies concluded staff nurses often believe nursing students take too much of their time (Amann & Williams, 1960; Jackson & Neighbors, 1988; Matsumura et al., 2004), recommending collaboration between nurse faculty and nursing administrators for development of quality clinical experiences that benefit both nurses and students (Jackson & Neighbors, 1988; Matsumura et al., 2004).

A 2002 mixed methods study by Birx and Baldwin found that collaboration between a school of nursing and nursing administrators was effective. Prompted by reports that the biggest stressor for nursing students was being loathed by staff nurses in the clinical education environment, Birx and Baldwin (2002) implemented a professional development strategy. Watson's theory of caring, taught to nursing staff and nursing students, was used to develop a clinical orientation program conducted by unit nurse managers for students, resulting in students who felt welcomed by the nursing staff (Birx & Baldwin, 2002). Their findings have provided support to subsequent studies that found nursing students who feel welcomed, included, and valued by staff nurses have greater confidence in developing clinical skills as opposed to negative encounters with nurses, which can hinder learning (Levett-Jones et al., 2008; Vallant, 2006).

Nursing students' encounters with staff nurses' incivility. Research (Martel, 2015; Randle, 2003; Tecza et al., 2015; Thomas et al., 2015) indicates the persistence of incivility in clinical education has the potential for nursing students to learn this behavior from staff nurses during their clinical education and perpetuate the problem of incivility. In this review, nursing students provided the largest voice within the nursing education literature related to incivility in clinical education settings. Findings from mostly qualitative studies involving sophomore, junior, and senior bachelor of science in nursing (BSN) students as well as second-degree nursing students substantiate the findings discussed earlier in this review regarding staff nurses' attitudes toward nursing students. An overall theme of the findings was the positive or negative responses of staff nurses toward nursing students.

Three subthemes of uncivil staff nurse behaviors were derived from studies reporting nursing students' descriptions of negative experiences with staff nurses. Thomas and Burk's (2009) study, which focused on vertical violence in the clinical education setting, is included in the following sections because of their inclusion of staff nurses and nursing students. The first subtheme was the lack of time staff nurses had for nursing students (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015). To provide perspective, clinical faculty can have up to ten nursing students in a clinical group, limiting faculty members' opportunities for observing and assisting nursing students' performance of nursing care, even though some patients may need intervention in the

present moment. Therefore, without the presence of an instructor, nursing students can miss opportunities to perform nursing skills.

Anthony & Yastik's qualitative study (2011) found students who asked staff nurses questions about nursing care were referred back to their instructor, claiming they believed it was not their job to educate students. In the United Kingdom, staff nurses who ignored or dismissed nursing students seeking out learning opportunities were perceived as not having time for students (Thomas et al., 2015). Nurses offered excuses for these types of behaviors, such as being busy, but students did not believe this justified their disrespectful actions (Thomas et al., 2015).

A second subtheme of staff nurse incivility toward nursing students in the reviewed literature was staff nurses' disrespectful, rude behaviors. Students described several behaviors of staff nurses they deemed uncivil: (a) keeping their back turned toward a student who was trying to talk to them; (b) sarcastic laughter and remarks in response to students' questions or comments; (c) making facial expressions, such as rolling their eyes, when students asked to be shown an aspect of patient care; (d) unwillingness to assist students with nursing care; (e) failing to include the student when performing skills or tasks during patient care; (f) refusing to answer simple questions; and (g) publicly criticizing student performance in front of patients, peers, and staff (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; Thomas & Burk, 2009; Thomas et al., 2015). Sadly, a student in Anthony and Yastik's (2011) study noted if the nurse was nice to the patient, it meant the nurse would be nice to her. Perceiving the

nurses were annoyed, disinterested, or hostile with their presence surprised the nursing students, mostly because these were members of a caring profession (Anthony & Yastik, 2011; Martel, 2015; Thomas; 2015; Thomas & Burk, 2009). These experiences reportedly made nursing students feel like they were a nuisance to staff nurses. They described feeling degraded, patronized, belittled, excluded, invisible, unsupported, defeated, unwelcomed, and unwanted (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; Thomas & Burk, 2009; Thomas et al., 2015).

A third subtheme of staff nurse incivility toward nursing students was the staff nurses' disregard for patient care provided by nursing students. Specific staff nurse behaviors that gave nursing students this perception were (a) throwing nursing students' patient reports in the trash without reading them, (b) questioning students' abilities in a sarcastic manner, (c) walking away when students asked for help and guidance, (d) questioning students' competency and ability to perform simple tasks, and (e) distrusting students' assessment findings (Anthony & Yastik, 2011; Martel, 2015; Thomas & Burk, 2009; Thomas et al., 2015). Experiencing these staff nurse behaviors reportedly made students feel like hired help, as well as discouraged, unconfident, unappreciated, demeaned, and belittled (Anthony & Yastik, 2011; Martel, 2015; Thomas & Burk, 2009). Anthony & Yastik (2011) provided an account of a student who was told by the busy clinical faculty member to ask for the nurse's assistance with a dressing

change. The nurse proceeded to tell the staff the students did not know what they were doing and told the nurse manager they should not be on the floor (Anthony & Yastik, 2011).

Negative Effects of Incivility During Clinical Education of Nursing Students

The negative effects of nursing students' experiences with these uncivil behaviors are a cause of great concern. The sections that follow will illustrate the physical, mental, and academic tolls these experiences take on students. Additionally, the negative effect on the nursing profession and the risks to patients' quality of care and safety will be explained.

Psychological effects of staff nurse incivility. Nursing students reported being affected psychologically with stress, anxiety, and dread of attending clinical education experiences (Martel, 2015). Thomas and Burk (2009), exploring unjust nursing behavior as a form of vertical violence, found anger was provoked in nursing students mostly from hostile clinical environments compared to classroom environments. Suppression of this anger led to physical and psychological consequences. Similarly, Thomas (2015) found nursing students were angered as a result of staff nurse incivility. Despite a long period of time since the uncivil encounters, Thomas (2015) described participants' episodes of prolonged crying when they were asked about their experiences. Martel (2015) reported similar findings, noting experiencing incivility from staff nurses caused

students to reconsider the profession of nursing as caring. Students "did not believe that they would be deemed worthless by the people they had respected" (Thomas, 2015, p. 116).

Physical effects of staff nurse incivility. Martel (2015) found staff nurses disregarded the physical safety of the nursing students and the patients to which they were assigned. In this qualitative study of senior BSN students, a student described a nurse's lack of concern after the student was struck by a patient. Instead, the nurse instructed the student to help the agitated patient ambulate with an IV pole and catheter bag, which the student felt increased the risk of the patient's safety (Martel, 2015).

Academic effects of staff nurse incivility. Staff nurses experiencing stress from work overload have led to the development of negative learning experiences for nursing students (Thomas et al., 2015). A quantitative study by Babenko-Mould and Laschinger (2014) found negative learning environments affected nursing students' well-being and caused burnout. Nursing students who perceived their patient care had been disregarded by staff nurses reportedly felt discouraged and unappreciated (Anthony & Yastik, 2011; Martel, 2015; Thomas & Burk, 2009). This led nursing students to stop asking staff nurses for learning experiences (Thomas, 2015). It also led nursing students to question both their ability to complete the nursing program and their decision to become a nurse (Anthony & Yastik, 2011). Students in Martel's (2015) qualitative study feared they would become like the uncivil nurses from whom they were learning.

Thomas et al. (2015) reported the value system of staff nurses can transfer to nursing students during their clinical education, ultimately affecting students' abilities to provide quality nursing care.

The Clinical Learning Environment

The work culture of clinical learning environments can affect learning opportunities for nursing students. Expanding the literature review to include studies of clinical learning environments helped to provide another perspective of staff nurses' experiences with nursing students in the clinical education environment. Hegenbarth, Rawe, Murray, Arnaert, and Chambers-Evans (2015) studied clinical learning environments and discovered the work culture of a nursing unit can affect the clinical learning environment of nursing students. Staff who make an effort to welcome students and make them feel a part of the team were described as contributory factors to a positive learning environment (de Fulvio, Stichler, & Gallo, 2015; Hegenbarth et al., 2015). In contrast, staff nurses can become angry or aggravated by the additional responsibility of having to educate nursing students in addition to their assigned patients (Hegenbarth et al., 2015). As evidenced in the literature, added workload causes staff nurses to experience stress, and if opportunities are not taken to intervene, incivility in the learning environment can occur (Clark et al., 2011).

The learning environment within clinical settings can be influenced by other contextual factors including staffing, patient acuity levels, and students' motivation to learn (de Fulvio et al., 2015; Hegenbarth et al., 2015). Each factor has the potential to

contribute additional stress to the clinical education environment. Support from nurse management can help mitigate negative influences on the clinical learning environment by encouraging collaboration between staff nurses and nurse educators as well as the provision of professional development for potential preceptors (de Fulvio et al., 2015; Hegenbarth et al., 2015). Incivility has implications for nursing education in the classroom and clinical settings as well as the workplace of staff nurses. "If we are committed to fostering healthy work environments . . . essential elements of this type of environment . . . need more formal emphasis within nursing curricula" (Luparell, 2011, p. 94).

Effects of Incivility During Clinical Education on the Nursing Profession and Patients

Experiencing staff nurse incivility creates a desire in some nursing students to cease their nursing education or to reconsider a career in the nursing profession (Anthony & Yastik, 2011; Martel, 2015); this has the potential to restrict growth of the nursing profession. New nurse graduates and experienced staff nurses have expressed a desire to leave the nursing profession due to workplace incivility and bullying (Hutchinson & Jackson, 2015; Nicholson, Leiter, & Laschinger, 2014). These findings provide greater emphasis for preventing incivility from occurring in clinical education settings due to the perpetuation of incivility, indicating a gap in the literature of staff nurses' experiences and perspectives of what leads to the perpetuation of this phenomenon.

Patient safety and quality of care are jeopardized in uncivil environments. Thomas and Burk (2009) reported hostile work environments can cause patient harm. Moreover, accrediting bodies and nursing organizations agree on the most important reason to find a solution to incivility in the nursing profession: compromised patient care (ANA, 2015b; ISMP, 2013; Joint Commission, 2008). Anthony and Yastik (2011) noted gaps in communication could harm patients. Students in Anthony & Yastik's (2011) qualitative study described reporting patient needs to nurses who responded sarcastically and even threw patient reports in the trash, resulting in ignored patient reports and discouraging additional student reports. Nursing students in Martel's (2015) qualitative study reported nurses were mean and disrespectful toward their patients, demonstrating a poor bedside manner. Not only have these behaviors negatively affected the quality of patient care provided, but staff nurses modeling this behavior can lead to nursing students incorporating this behavior into their practice (Luparell, 2011).

Contributing Factors to Incivility During Clinical Education of Nursing Students

The conceptual model for fostering civility in nursing education, as adapted practice, was used as a framework for the sections that follow (Clark et al., 2011). A component of this model outlines contributors to stress in nursing practice. Many studies from this review supported the model by Clark and her colleagues (2011) as it relates to nursing practice. However, these relationships were made based on nursing students' interpretations of their experiences with staff nurses. Additionally, limited

studies in this review supported the component of this model outlining contributors to stress in nursing education. Gaps in the literature were found pertaining to understanding what staff nurses consider contributing factors to stress and incivility during clinical education with nursing students and the contributing factors to stress in nursing education as it relates to clinical settings.

High acuity patients and increased workloads. Thomas and her colleagues (2015) noted staff nurses stressed from work overload, who are also mentoring nursing students, can create negative learning environments for these students. Martel's (2015) qualitative study of seven senior nursing students described busy staff nurses working within a clinical education setting were perceived by nursing students as unwelcoming. Thomas and Burk (2009), seeking to understand nursing students' perceptions of vertical violence, conducted a longitudinal study. Over a three-year period, they asked junior-level nursing students to submit individual narratives of a time they experienced anger related to nursing classes or clinicals. After analyzing 221 narratives, Thomas and Burk (2009) found students felt angry more in clinical settings than in the classroom and the suppression of this anger led to physical and psychological effects. A participant described being ignored and discouraged when the staff nurse she was assigned to follow in the emergency department performed personal searches on the Internet instead of helping her learn (Thomas & Burk, 2009).

Poor interpersonal relationships. Most of the reviewed studies described the effect staff nurses' verbal and non-verbal communication had on nursing students.

Communication is integral in developing and maintaining professional relationships and for increasing the quality of patient care, yet nurses' behaviors have led students to perceive nurses had no time for them and had no interest in the patient care the students were providing (Anthony & Yastik, 2011; Cronenwett et al., 2007; Martel, 2015; Thomas et al., 2015). Staff nurses ignored, excluded, and refused to help students, threw students' patient reports in the trash, rolled their eyes at them, and reacted with sarcasm (Anthony & Yastik, 2011; Martel, 2015; Thomas et al., 2015). Based on the review of these studies, a gap in the literature was identified to determine the effect of incivility on the relationships of staff nurses and students.

Organizational conditions/volatility. A concerning exemplar of how organizational conditions and their volatility contribute to incivility in clinical education settings was found in Hutchinson and Jackson's (2015) study of workplace bullying occurring in the public sector. This Australian study of employees, including nurses, used a mixed methods survey to determine how care failures in a healthcare organization contributed to uncaring internal cultures. When the organization shifted to neoliberal market principles and sought to develop an efficiency-driven enterprise, multi-level tensions developed among administrators and managers (Hutchinson & Jackson, 2015). The leaders of the organization used their power to bully staff into conforming to the identity the organization wanted to present, ultimately leading to the filing of internal and external complaints (2015). Hutchinson and Jackson (2015) reported a significant finding: Management could quote anti-bullying policies yet were

rewarded with promotions after bullying coworkers. Further, victims of bullying, who followed the anti-bullying polices by filing complaints of the abuse, were vilified and surveilled (2015). One employee reported being reassigned to a work site 90 minutes from his or her residence instead of the previous ten-minute drive as a result of filing a complaint of bullying (Hutchinson & Jackson, 2015). The actions by the organization reported in this study resulted in the resignation of employees, including nurses (Hutchinson & Jackson, 2015).

Lack of support from nurse managers can contribute to uncivil staff nurse behaviors. Walrafen, Brewer, and Mulvenon (2012) used a mixed methods approach with 227 nurses in a multi-institutional hospital system to determine the prevalence of horizontal violence, a form of workplace violence occurring between nurses. Staff nurses had reported a problem for which the nurse manager did not intervene; therefore, they unwittingly used horizontal violence an attempt to solve the problem (Walrafen et al., 2012). Despite their surprise when they learned, through participation in the study, their behaviors were considered horizontal violence, they felt their behaviors were justified due to the lack of support they received from their nurse manager (Walrafen et al., 2012).

Unclear roles and expectations, and imbalance of power. Staff nurses did not seem to understand their role or what was expected of them when nursing students were present on their clinical units for clinical education (Martel, 2015; Thomas et al., 2015). Nursing students described being left on their own, ignored, and dismissed by

the staff nurses on their clinical unit (Martel, 2015; Thomas et al., 2015). Nurses did not acknowledge the assistance the nursing students provided for their patients, making students feel inadequate (Martel, 2015). Nursing students who asked nurses for help with patient care felt disregarded and unsupported (Thomas, 2015).

Lack of knowledge and skills in managing conflict. A lack of knowledge in managing conflict during clinical education exists. Nursing students admitted they were surprised by staff nurses' uncaring behaviors (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015). It follows that if students are surprised by uncivil staff nurse behaviors, they have no knowledge that the potential for uncivil encounters exists. Studies supporting this correlation found students were unprepared to address these behaviors during clinical education. Junior and senior nursing students in Thomas' (2015) qualitative study reported that not knowing how to handle uncivil encounters led to physical and psychological turmoil. Nursing students feared they would receive a poor clinical evaluation due to misconduct if they reported their encounters; instead, they stopped requesting learning opportunities from the nurses (Thomas, 2015).

Strategies Used to Prevent or Disengage From Incivility During Clinical Education

Literature from this review has put forth several strategies to mitigate incivility in clinical education settings. However, most of the strategies addressed what nurse educators and nursing students could implement in the classroom to raise student awareness of uncivil behaviors and how to respond if incivility is encountered. The

literature review was expanded to include research of strategies for preventing disruptive behavior, horizontal violence, and vertical violence.

The prevalence of incivility and other types of disruptive behaviors in healthcare settings have prompted responses from governmental agencies, healthcare agencies, and nursing education. The Centers for Medicare and Medicaid Services measure and correlate reimbursement to healthcare agencies to patient outcomes and patient satisfactions scores, which are decreased in the presence of incivility. Multiple governing and accrediting bodies have written guidelines, white papers, and policies to address the issue of disruptive behaviors in healthcare (AMSN, 2012; ANA, 2006, 2014, 2015b; Joint Commission, 2008; NCSBN, 2011; OSHA, 2004). Yet a survey of nurses, doctors, pharmacists, and quality/risk management staff conducted in 2013 by the Institute for Safe Medication Practices found the same results as their 2003 survey. They noted that physicians and other prescribers engaged in disrespectful behavior most often. As a result, nurses intimidated by this type of behavior prioritized their reluctance to question medication orders over ensuring their patients' safety (Beckmann & Cannella, 2015; Zimmerman & Amori, 2011).

Despite these efforts, studies in this review demonstrated the continuation of disruptive behaviors in clinical settings. Fortunately, these studies have also provided strategies that can be tested in future studies. Educating healthcare workers on effective strategies can initiate the process of curbing incivility. Participants from a study by Walrafen and her colleagues (2012) suggested several strategies that could

potentially help with preventing incivility. Examples included (a) educating nurses on the specific behaviors perceived as uncivil, (b) developing cultural insensitivity toward fellow staff nurses by implementing cultural awareness campaigns, and (c) to "do unto others as you would have done to you" (Walrafen et al., 2012, p. 10). Participants also suggested professional development to prepare nurse managers to quickly stop horizontal violence and provide action on violent behaviors (Walrafen et al., 2012).

Once staff nurses have been educated, they must make individual decisions based on the information they have received. Staff nurses in the study by Walrafen and her colleagues (2012) suggested nurses should commit to being a part of the solution to improve collegiality. Nurses who perpetuate negative behaviors should take personal responsibility for these actions and do the right thing for their fellow nurses (Walrafen, 2012). Perhaps the most important suggestion found in this study was for nurses to recommit to the *Code of Ethics for Nurses* and to the professional code of conduct of their respective organizations.

After staff nurses have been educated about incivility and other disruptive behaviors, they must follow through with appropriate actions. Anthony and Yastik (2011) noted incivility could decrease in clinical education settings if staff nurses modeled expected behaviors and supported nursing students. Practicing behaviors deserving of respect can lead to civil work environments (Lux, Hutcheson, & Peden, 2014). Similarly, Nicholson and colleagues' (2014) longitudinal analysis of cynicism as a function of trust and civility among Canadian nurses found workgroup civility diminishes

workplace cynicism. Therefore, they suggested employees be provided with "concrete, simple methods of interacting with their co-workers and supervisors instead of attempting to remove all uncivil acts from the workplace" (Nicholson et al., 2014, p. 976).

Within the last 10 years, recommendations for establishing policies for zero tolerance of disruptive behaviors in the workplace have been made by agencies governing healthcare facilities and healthcare researchers (Center for American Nurses, 2008; Joint Commission, 2008). Thomas and Burk (2009) agreed that zero tolerance institutional policies should be in place where students engage in clinical learning. However, policies must be consistently enforced to be effective. Hutchinson and Jackson (2015) sampled 3,345 public sector employees in Australia for a cross-sectional survey to determine how healthcare organizational cultures develop an antithesis to caring. They found managers and administrators could quote anti-bullying policies but managed with and rewarded bullying tactics. Unfortunately, none of the perpetrators of the bullying behaviors were punished, despite having anti-bullying policies in place (2015). Walrafen and her colleagues (2012) concluded preventive strategies should be used, noting lateral violence stops when a nurse confronts the abuser, which may be effective when the powers within a healthcare agency are supportive of anti-bullying behavior.

Nurses in any role have an ethical obligation to maintaining a civil work environment (ANA, 2015a). Walrafen and her colleagues (2012) suggested that nurses

should recommit to the Code of Ethics for Nurses. The *Code of Ethics for Nurses* (the *Code*) provides specific guidelines for how nurses should interact with all individuals. Perhaps not all nurses are aware of the *Code* or they may be aware of this document but not its contents. This identifies a gap in the literature and a need to explore staff nurses' knowledge of the *Code*. Additionally, if they are found to be knowledgeable of its contents, what do staff nurses identify as the reasons or barriers for not following nurses' code of ethics?

Inferences for Current Study

The use of qualitative studies provided rich descriptions of nursing students' experiences with incivility in the workplace of nurses, which have also implicated staff nurses as perpetrators of this unethical practice (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; Thomas et al., 2015). However, no published studies were found providing descriptions of staff nurses' experiences of incivility with nursing students in clinical education settings. Therefore, an aim of this study was to explore registered nurses' experiences and perceptions about incivility with nursing students in clinical education environments within hospital settings.

In several studies, nursing students used rich descriptions to explain what they perceived to contribute to incivility in clinical education settings: (a) nurses having limited to no time to spend toward educating students during patient care (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015); and (b) staff nurses not wanting students on their clinical units (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; Thomas &

Burk, 2009; Thomas et al., 2015). Staff nurses needed an opportunity to describe for themselves what contributes to these encounters, thereby establishing a second aim of this study. In so doing, stakeholders of clinical education for nursing can gain a better understanding of this phenomenon and be better prepared in addressing this important issue with nursing students and registered nurses.

Multiple studies outlined strategies on addressing incivility experienced in clinical education environments, mostly from the perspective of nursing education. Unfortunately, physical and psychological effects can occur after any experience with incivility. Expanding the review of literature to include studies on horizontal violence and disruptive behaviors described staff nurse perspectives from two studies. A gap in the literature exists of a deeper understanding of recent, successful strategies used by staff nurses in hospital settings to prevent or disengage from incivility with nursing students during clinical education. Gaps also exist to determine if staff nurses have used these strategies successfully and also what barriers have prevented them from implementing any strategies. Therefore, a third aim of this study was to explore measures used by staff nurses to prevent or disengage from encounters with incivility during the clinical education of nursing students.

Summary

This chapter provided the current state of incivility in clinical education settings as related to staff nurses and nursing students. This review identified gaps in the

literature warranting an exploration of registered nurses' experiences and perspectives with this phenomenon. An explanation of how the conceptual framework guided this study was also provided, concluding with inferences for this study.

CHAPTER 3

METHODOLOGY

This chapter explains the research methodology and research design that was used to conduct the current study. Explanations about descriptive phenomenology and the rationale for using this approach are presented. Descriptions of the setting, sampling procedure, participants, data collection, processing of data, and analysis procedures are provided in this chapter. Additionally, information regarding human subject protection and methods to maintain confidentiality is delineated. The chapter concludes with a discussion of how trustworthiness and rigor were established and the limitations of this study.

Research Method and Design

The research question in this study was addressed using a qualitative approach with descriptive phenomenology. Utilizing this approach allowed for the direct exploration of what it is like for registered nurses to encounter incivility during the clinical education of nursing students within hospital settings. The goal of this type of inquiry was to provide a careful description, based on the descriptive accounts of selected individuals, of what it is like to experience a phenomenon whereby an understanding of the lived experience of the phenomenon from people who have

actually experienced it can be achieved (Creswell, 198; Husserl, 1931/1962; Lobiondo-Wood & Haber, 2010; Polit & Beck, 2012; Streubert & Carpenter, 2011). Giorgi's (2009) data analysis process informed and guided the procedural steps taken to describe the essence of the phenomenon of interest. In the context of this study, the phenomenon of interest was registered nurses' experiences of incivility with nursing students during clinical education in hospital settings.

Phenomenology, introduced in 1913 by German philosopher and mathematician, Edmund Husserl, is both a philosophy and a theoretical research approach (Giorgi, 2009; Munhall, 2012). Husserl's philosophical approach provides a framework for understanding "anything at all that can be experienced through the consciousness one has of whatever is 'given'--whether it be an object, a person, or a complex state of affairs--from the perspective of the conscious person undergoing the experience" (Giorgi, 2009, p. 4). Phenomenology assumes this subjectivity forms unquantifiable mental phenomena contained within an individual's consciousness as intuitive knowledge (Giorgi, 1985; Husserl, 1931/1962). An individual gains intuitive knowledge by experiencing objects within his or her everyday world (Husserl, 1931/1962). In other words, "the world is knowable only through the subjectivity of being in the world" (Munhall, 2012, p. 127). However, the natural knowledge contained in these experiences remains in these experiences (Husserl, 1931/1962). Therefore, to derive

the knowledge from those who have experienced the phenomenon of interest, a qualitative method using phenomenological inquiry was appropriate for this study.

The conceptual framework of Husserl's transcendental phenomenology consists of the concepts of intentionality and intuition (Moustakas, 1994). Intentionality is a fundamental, phenomenological account of the relationship between the consciousness of the mind and the world, providing the groundwork for descriptive phenomenology (Gallagher & Zahavi, 2008; Moustakas, 1994). Intentionality is when one's consciousness is directed toward an object in the world, forming a perception of the seen or unseen phenomenon, and assigning meaning to it by experiencing it (Gallagher & Zahavi, 2005; Moustakas, 1994). The meaning assigned to this experience remains within the consciousness of the perceiver, forming a subjective mental representation of the encountered object, shaping the perceptions one has of it in the world (McIntyre & Smith, 1989; Moustakas, 1994). This process forms intuitive knowledge, which does not lend itself to discovery through a scientific approach (Giorgi, 2009). Mohanty (1989) illustrated this concept with the following example:

> If I am thinking of the planet Venus, that planet is the object of my thinking – what I am thinking about. But if I ask myself, as what am I thinking of that planet, I am trying to ascertain the intentional content of my thinking. To use a familiar locution, under what description am I thinking of that planet? Another locution will do, if only we avoid some misleading features of that locution: when I am thinking of that planet, how is it represented in my thought? (p. 67)

Intuition is evidenced by the consciousness of existing objects encountered in the world, therefore, it is where the knowledge of the everyday human experience is derived (Husserl, 1931/1962; Moustakas, 1994). Intuition is necessary for describing what is presented to one's consciousness because the datum of pure essence is contained in the description (Husserl, 1931/1962; Moustakas, 1994). The units of meaning gleaned from the essential data show the validity of the reality of the phenomenon and provide essential insight into its existence (Husserl 1931/1962).

Based on the conceptual framework of phenomenology, it follows that a descriptive phenomenologically-designed inquiry is appropriate to analyze the intentionality derived from the intuitive knowledge of several individuals based on their descriptive, experiential accounts with the phenomenon under investigation. The methodology of this inquiry includes the core processes of epoché, phenomenological reduction, and imaginative variation which are used to derive knowledge from the participants (Giorgi, 2009; Husserl, 1931/1962; Moustakas, 1994). Epoché, also called bracketing, is a natural standpoint whereby the researcher becomes a learner who sets aside past knowledge and preconceived judgments while maintaining sensitivity to the phenomenon under investigation (Giorgi, 2009; Husserl, 1931/1962; Moustakas, 1994).

Phenomenological reduction is the process of taking the objects of experience as presented and reducing them to phenomena by utilizing a naïve approach to the raw data (Giorgi, 2009). This process leads back to the source of the meaning of the

experienced world while preventing bias and relating the experience straightforwardly (Giorgi, 2009; Moustakas, 1994). Moreover, the researcher can understand the participants' perceptions of the experience by utilizing phenomenological reduction (Husserl, 1931/1962). Imaginative variation allows the researcher to use his or her own imagination to distinctively intuit the data and derive a "structural description of the essences of the experience and connect with it" (Moustakas, 1994, p. 35). This rigorous process will render an understanding of the meaning of the phenomena (Husserl, 1931/1962).

By exploring the intentionality of the participants, great insight about the phenomenon can be discovered due to the different perceptions each individual has of it (Gallagher & Zahavi, 2008; Husserl, 1931/1962). Perception is shaped by each individual's prior experience with the given object within various contexts, thereby bringing different meanings to the same experience (Gallagher & Zahavi, 2008). Through the researcher's use of open-ended questions and observations, participants will form a factual account of the essence of the phenomenon by describing their eidetic descriptions, which are vivid pictures, of their actual experience within reality (Husserl, 1931/1962). The descriptions given from the participants are purely and truly attached to the data of intuition (1931/1962). These data can be analyzed and interpreted to provide factual knowledge to those who have not experienced the phenomenon (Husserl, 1931/1962).

Giorgi (2009) outlined a rigorous method to aid in the analysis of qualitative data provided by the narrative descriptions of participants: (a) employing intuiting, (b) phenomenological reduction, and (c) imaginative variation. Phenomenological reduction provides a fresh, non-biased approached to the raw data to which nothing is added or taken away (Giorgi, 2009). To begin the analysis, each descriptive narrative is read in its entirety to obtain a sense of the whole followed by a second reading used to intuitively identify "meaning units" from the descriptions (Giorgi, 2009, p. 129). Maintaining a phenomenological attitude, the researcher seeks to put the meanings of the experiences of the participants together to form both a statement and a description of what it is like to encounter the phenomenon (Giorgi, 2009). Through this rigorous yet careful phenomenological approach, a factual description of the essence of the phenomenon and what it is like to experience it is formed (Giorgi, 2009). Although this type of inquiry offers a different view point of phenomena compared to the older sciences (Giorgi, 2009; Husserl, 1931/1962), it offers a logical and rigorous form of qualitative research for analyzing the lived experience of phenomena (Streubert & Carpenter, 2011) which can "provide unique perspectives, has the ability to guide nursing practice, contribute to instrument development, and develop nursing theory" (LoBiondo-Wood & Haber, 2010, p. 102).

Schön's (1983) reflection-in-action theory was utilized in this qualitative approach to reveal the tacit knowledge of registered nurses who have experienced

uncivil encounters with nursing students, allowing for exploration of their knowledge to gain a particular insight not afforded by quantifiable means. Interpretation of or response to repeated situations can vary based on the past experience of the individual and whether or not they have spent time reflecting on it. In this study, registered nurses who experienced incivility during the clinical education of nursing students in hospital settings were invited to share their experiences. Registered nurses were asked to reflect on and describe their perspectives of this phenomenon and the actions they took to either prevent or disengage from their uncivil encounters. They were also asked to reflect on and describe contributing factors they perceive led to the uncivil experience. "When practitioners reflect-in-action, they describe their own intuitive understandings" (Schön, 1983, p. 276), allowing for the analysis of these revelations.

Rationale for Research Approach

The purpose of this study was to explore the experiences of registered nurses' encounters with incivility during the clinical education of nursing students. Within the narratives of these human experiences are vivid descriptions that can illuminate the essence of the phenomenon and give it meaning (Moustakas, 1994). Describing the essence, "basic units of common understanding of any phenomenon" (Streubert & Carpenter, 2011, p. 75), of incivility in this context will allow individuals with no experience with this phenomenon to gain a deeper understanding of what it is like to experience it (Polit & Beck, 2012; Saldaña, 2011; Streubert & Carpenter, 2011).

Obtaining this “stable knowledge about human phenomena” (p. 70) is a human science, not a natural science, requiring qualitative methods that can access participants’ knowledge of the essence of a phenomenon gained from intuition and reflection (Giorgi, 2009; Moustakas, 1994). Phenomenological inquiry is important to the discipline of nursing because describing salient phenomena encountered by nurses contributes to the evolving research within the nursing discipline, thus creating growth in nursing knowledge (Streubert & Carpenter, 2011).

Further, qualitative research can provide valuable information that can be used by staff nurses, nurse educators, and healthcare administrators to create and maintain safe work and clinical education environments as well as improve patient outcomes. The resolution of incivility in clinical education settings is essential to maintaining open communication and collaboration between staff nurses and nursing students which can lead to the provision of safe, quality care to patients, and ultimately improved patient outcomes (AACN, 2016; Cronenwett et al., 2007). Despite a sentinel event alert from the Joint Commission in 2008 to address intimidating and disruptive behaviors from healthcare teams, incivility continues to permeate nursing units where uncivil behaviors among nurses in acute care settings have continued (AMSN, n.d.; Hunt & Marini, 2012; Lucian Leape Institute, 2013; Luparell, 2011; NCSBN, 2011). Consequences of these uncivil behaviors, which are occurring in the midst of an increasing nursing shortage, present a challenge of addressing incivility in clinical education settings (Anthony &

Yastik, 2011). The nursing profession needs to understand the essence of incivility in the context of this study to allow mitigation of the issues it causes. A descriptive qualitative approach helped toward achieving this end goal.

Using descriptive phenomenology allowed participants in this study to provide detailed descriptions of their experiences. The data analysis from these narratives provided a way for stakeholders to comprehend how registered nurses are affected by encounters with incivility. Additionally, participants were asked to identify what they perceive to be contributing factors to uncivil encounters and what successful strategies they implemented to prevent or disengage from them. Results from the analysis of these descriptions can be used to inform healthcare policies, educate staff nurses, and provide teaching strategies for nurse educators. The findings from the rigorous phenomenological analysis of the factual descriptions from participants who have experienced incivility as registered nurses during the clinical education of nursing students formed a firm foundation for further research, including empirical studies.

Setting

Individual face-to-face interviews of registered nurses took place in private conference rooms at my educational institution. Some participants needed the convenience of an interview over the telephone. FaceTime® was also utilized.

Participants

A purposive sample of registered nurses who have been employed full-time for at least two years in either hospital settings or nursing education was invited to participate in this study. This sampling method was ideal for this descriptive phenomenological inquiry because I was able to select participants based on their first-hand experience with the phenomenon of interest. Their experiences made them the most informed about the phenomenon of interest (Polit & Beck, 2012; Streubert & Carpenter, 2011). Their experiences provided a deeper understanding of the phenomenon under investigation.

Participants were selected for the purposive sample based on the following inclusion criteria: (a) registered nurse employed a minimum of two years on a hospital clinical unit or in a faculty role at the time of the uncivil encounter; (b) reported having had an uncivil encounter during his or her career with at least one nursing student, who was present in the hospital setting to receive clinical education; and (c) possessed the ability to read, write, and comprehend the English language. A purposive sample of registered nurses who met these criteria provided rich, detailed descriptions of experiencing the phenomenon of interest.

Data Gathering

Potential respondents were invited to participate in this study after approvals were obtained from Mercer University Institutional Review Board (IRB) and the selected

research sites. Recruitment for study participation was initiated by sending an invitational email (see Appendix F), which also contained a description of the study, to the representative of each research site who was authorized to forward the email to all registered nurses affiliated with the respective organization. With permission from the administrators at one research site, invitational flyers describing the purpose of the study and the researcher's contact information were displayed in conspicuous areas of the healthcare organization (see Appendix B). A $25 gift card to Target was offered as an incentive for participating in this study. This information was included on the flyer and in the invitational email. Once I received a response from a registered nurse who was interested in participating, I communicated with this person via telephone or email and provided additional information related to this study. This communication with the respondent allowed me to answer questions, review the inclusion criteria and demographic data to be collected, and emphasize his or her right to terminate participation in this study at any point. Each respondent was informed regarding the recording of the interview, my making handwritten field notes during the interview session, the measures to ensure confidentiality, and a reference for psychological counseling if needed once data collection ended.

The sample size was anticipated to be 10 to 12 participants, with thirteen participants comprising the final sample. Invitational emails and flyers requested registered nurses to respond if they were interested in participating in this study. My

contact information was included in each method of communication. A date, time, and location for the interview session to take place were determined once each respondent was informed of and agreed to participate in the study. The recruiting process began June 2017 with interviews following subsequently. Data collection ended November 2017 when my dissertation chair and I concluded through ongoing data analysis that data saturation had been reached, at which time no additional participants were sought.

Prior to the collection of any data, each participant reviewed and signed the informed consent (see Appendix C). Once the participant agreed to a face-to-face interview session, I obtained informed consent on the day of the interview. Conversely, if the participant agreed to a telephone interview, I emailed the informed consent to the participant prior to the interview session. The participant was asked to read, sign, and return the consent form by fax or a scanned attachment via email. The interview sessions occurred on a date and time convenient for both the participant and me.

Confidentiality of participants' responses were maintained by conducting the individual interviews in a private meeting room. Verification that the participant had reviewed and signed the informed consent along with the collection of demographic data occurred prior to turning on both of the digital recording devices. The following demographic information was collected: (a) age, (b) gender, (c) highest level of nursing education, (d) years of registered nurse experience, (e) type of hospital clinical unit where incivility took place, (f) role on this hospital clinical unit when incivility took place,

(g) length of employment as a registered nurse on the hospital unit or as clinical faculty, (h) previous experience as a clinical educator or preceptor for nursing students, (i) approximate date of most recent uncivil encounter with a nursing student, and (j) approximate number of encounters with incivility with nursing students in a hospital setting during career. Semi-structured interviews were conducted to allow participants the freedom to illustrate and describe their encounters with incivility using their own words. Additionally, field notes were used to record observations such as body language and emotional responses. A journal was kept to record the researcher's observations, feelings, attitudes, and values relative to the interview process and those who were interviewed, and throughout the entire research process. When the interviews were completed, participants were offered the gift card incentive.

The interview guide (see Appendix D) used open-ended questions along with probing questions to elicit responses from participants. The researcher conducted each interview with the mindset that the outcome of the interview was to understand what the experience meant for those who were a part of it (Giorgi, 2009). The following statements are examples found in the interview guide:

1. Think back over your experience as a registered nurse in a hospital setting and describe an experience with incivility you encountered during the clinical education of nursing students in a hospital setting.
    a. How did this experience affect you?

2. What contributing factors led to this encounter?
    a. What attitudes or behaviors did this student exhibit during this act or acts of incivility?
    b. What attitudes or behaviors did you exhibit during this act or acts of incivility?
3. Describe how you attempted to prevent this encounter or to disengage from this encounter.
    a. Have you attended professional development or continuing education courses that provided ways to address incivility? If "yes," have you used the strategies provided? Why or why not?
    b. How has the *Code of Ethics for Nurses* affected your experiences with nursing students on your clinical unit?

Protection of Human Subjects

For this study, the researcher obtained permission from the study sites and approval from the Mercer University institutional review board (IRB). After obtaining approval from the Mercer University IRB, invitational emails explaining the study to potential participants were sent to a representative of each research site for distribution to the registered nurses affiliated with each organization. Respondents to the invitational email were informed of the purpose of the study, had the opportunity to ask

questions, and were not pressured to participate. These individuals were asked to sign an informed consent prior to the initiation of data collection and were reminded of their freedom to withdraw from the study at any time.

Participants were assured of the confidentiality of their personal information and the information provided during the interviews. Confidentiality of the participants was maintained by conducting interviews in a private meeting room at the researcher's institution. Before digital audio recording began, participants were asked demographic questions and the answers were hand-recorded on the demographic data form. A self-selected pseudonym by the participant was also hand-recorded on the demographic sheet. The pseudonym was used to identify the participant in the field notes, transcribed narratives, and all other aspects of the dissertation process. The audio recordings and interviewer notes, both written and stored on the computer, were kept in a locked location accessible only by me.

A transcription company was hired to transcribe the digital audio recordings of the interviews verbatim. A signed confidentiality agreement was obtained from the company prior to obtaining any data for this study (see Appendix E). This agreement discussed the privacy and confidentiality of participants and the requirements for possession of data from the study. The transcription company assured all files pertaining to this study would be deleted after transcriptions were completed, including digital recordings.

Transcripts did not include identifying information of the participants, their fellow coworkers, nursing students, clinical faculty, patients, or the healthcare organizations. Identifiable information discussed in the interview sessions that could potentially identify these subjects was redacted and replaced with pseudonyms. Upon receipt of the transcribed narratives, I reviewed the documents to ensure there was no identifying information.

Documents containing identifiable information were kept in a secure file box. The information will be secured for the designated time period mandated by the IRB at Mercer University. When the time period has expired, all electronic data files pertaining to this study will be destroyed, including all digitally recorded interview sessions. The interview transcripts will not be destroyed as they contain no identifying information. Participants were informed that the narratives will be used for scholarly publications and presentations. I emphasized these narratives contained no identifiable information.

Participants encountered no physical harm during this study as participants responded to questions regarding an experience of a past event. Study participants were protected in regard to the sensitive nature of the phenomenon of interest. I had references for counselors available in the event a participant felt it was needed, but no participant made any such request. I journaled my thoughts regarding the emotions this subject matter elicited in me, but I did not feel the need to seek counseling.

Data Processing

Informed consent was obtained from each participant. Before recorded interviews began, demographic information from the participant was written on a demographic data sheet. The data sheet was labeled with the participant's self-selected pseudonym to ensure confidentiality. Demographic information was collected. After obtaining informed consent, demographic data, and the participant's pseudonym, I turned on two digital audio recording devices. The second device was used as a backup in case the first device malfunctioned.

Recorded interviews were sent to the professional transcriptionist electronically and were transcribed into a Microsoft Word document. Transcribed narratives received from the transcriptionist were backed-up on a password-protected computer and to an external hard drive. The documents and external hard drive were kept in a secure file box with the researcher. The dissertation chair was updated regularly on data processing and provided copies of the transcribed narratives. Access to digital recordings was not necessary.

Data Analysis

Data analysis began concurrently with data collection. I analyzed the data generated by the initial interviews to determine if questions were capturing the essence of the phenomenon of interest as participants described their experiences. Interview

questions were adjusted to help guide participants as they shared their descriptive stories. After the transcribed narratives were received, I verified them for verbatim adherence to the audio recordings to ensure their accuracy.

Once the transcriptions were verified for accuracy, a copy was sent to the dissertation chair. I spent time reflecting on the data gathered during this phenomenological process. Reflection on the collected data yielded the essence of the phenomenon of interest and allowed me to "capture the essentials of the experience that make it what it is" (Saldaña, 2011, p. 8). As Streubert and Carpenter (2011) noted, analyzing qualitative data is a hands-on process that requires the researcher to dwell with data by "reading, intuiting, analyzing, synthesizing, and reporting the discoveries" (p. 45) made known by the participants.

Giorgi's (2009) method was utilized to provide structure to the data analysis. The researcher began by bracketing any preconceived notions and judgments about the phenomenon of interest and documented them in a reflexive journal (Polit & Beck, 2012). Then the entire transcript was read, with an attitude of phenomenological reduction, to gain a "sense of the whole" (Giorgi, 2009, p. 128). This focus allowed me to obtain a universal awareness of the description strictly upon what was given by the participants regarding it (Giorgi, 2009). Additionally, field notes and journal entries were included in the first reading.

The next phase of Giorgi's (2009) method entailed reading the narrative description a second time to determine meaning units. Establishing units of meaning from the descriptions of the participants required the researcher to remain sensitive to the phenomenon under inquiry, allowing the meaning of the phenomenological experience to be understood (Giorgi, 2009). Significant shifts in meaning within the description were marked without a priori criteria and the lengthy descriptions were made more manageable (2009). The creation of these meaning units was not objective, but rather reflected the attitude and psychological sensitivity applied by the researcher (2009). Therefore, first-cycle coding began to be conducted concurrently during the second reading as attributes of the phenomenon of interest within the narrative began to emerge (2009). Coding methods delineated by Saldaña (2013) guided this process.

Coding is an analytical process of assigning symbolic codes, a word, or a short phrase to portions of the visual data that capture the essence of the phenomenon (Saldaña, 2013). The iterative process of codifying the data took more than one attempt, ultimately leading to categories of similarly coded data that was compared and refined (2013). The researcher recorded emerging patterns during the review and coding of the data and themes were formed as a result of this analytic coding process (2013).

The third step of Giorgi's (2009) method involved transforming the meaning units into a description of the phenomenon as it was experienced. This involved

dwelling with the coded data while implementing imaginative variation over a lengthy time period (2009). During this time, I imagined the data in different ways in order to "tease out" (p. 132) the meanings embedded in the concrete descriptions, integrating the data into general structures closely related to facts (Giorgi, 2009). Several versions of how to most accurately express the meaning units had to be written before the "desired expression" was achieved (p. 132). The end result was the transformation of a whole description into "a series of transformed meaning units" (p. 137) that described the phenomenon being investigated (Giorgi, 2009). This process allowed for the participants' descriptions to become the "general structure" (p. 137) of what it was like to experience incivility during the clinical education of nursing students within hospital settings (Giorgi, 2009).

Saldaña's (2013) coding processes enhanced the transformation of meaning units into themes and subthemes that represented the salient features of the phenomenon of interest. Reflection on the coded data was a part of the intuitive process the researcher applied as the third step of Giorgi's (2009) method. As a result, "an exhaustive description of the experience" (Lincoln & Guba, 2011, p. 46) was supported by a general structure based on the transformed meaning units and themes (Giorgi, 2009).

Trustworthiness/Rigor

Rigor in qualitative research was achieved by representing the experiences of the participants accurately (Streubert & Carpenter, 2011). Trustworthiness of the research provided confidence in the findings (Lincoln & Guba, 1985). Researchers within the conventional paradigm use internal validity, external validity, reliability, and objectivity to establish credibility and validity of their research findings; however, these methods are not congruent within the phenomenological paradigm (1985). Qualitative researchers can establish trustworthiness of their research findings by using Lincoln & Guba's (1985) criteria of credibility, dependability, confirmability, and transferability. Therefore, the criteria they delineated were used in this study to generate accurate findings that may be applicable in other contexts.

The process of credibility in this qualitative study incorporated prolonged engagement, persistent observation, and triangulation as discussed by Lincoln and Guba (1985). Spending enough time with each participant's data during the data gathering process helped the researcher understand the context of their experiences with the phenomenon of interest and also reduced distortions of the data due to misinformation or preconceptions (1985). Moreover, prolonged engagement with the data occurred with the reflections upon all narratives and through the discussions with the dissertation chair about the coding process and the identification of themes and subthemes.

Persistent observation provided depth to the findings and interpretations of this qualitative study by "identifying those characteristics and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail" (Lincoln & Guba, 1985). An analysis of the salient features attributed to the phenomenon of interest described by the participants were explored in detail. Further, the researcher was mindful to avoid premature closure of the interview process with the participants (1985).

Triangulation added to the credibility of the findings and interpretations by making the data more believable (Lincoln & Guba, 1985). Space triangulation, discussed by Streubert and Carpenter (2011), was implemented in this study by including registered nurses from among multiple nursing units in different hospitals in separate health systems. Using this strategy reduced the likelihood of encountering a participant known to the researcher or to other participants and provided variability within the purposive sample. A second type of triangulation, person triangulation, was used to collect data from more than "one level of person" (Streubert & Carpenter, 2011, p. 353). Person triangulation was achieved by using purposive sampling to incorporate registered nurses with varied years of nursing experience and different ages, gender, and roles.

A second technique used to establish credibility was peer debriefing (Lincoln & Guba, 1985). Allowing a second person to analyze and explore different aspects of the

study allowed me to clarify and defend decisions about findings and interpretations. My dissertation chair helped illuminate aspects of the study that I overlooked and provided fresh insight. She also routinely reviewed gathered data, participated in the coding process, and helped identify themes and subthemes.

Member checks are another technique suggested by Lincoln and Guba (1985) to establish credibility in which the researcher returns to the participants with the analyzed conclusions of the inquiry, allowing the members to react to the representations of their experiences. Lincoln and Guba (1985) admit that this technique is problematic in that the members may not agree with the final conclusions, leading the researcher to reconstruct the final analysis. Member checking can create additional problems, such as members who may not approve of being in an adversarial position, a group that conspires to mislead the researcher, and confusion by the researcher who may use this technique as a form of triangulation (1985). Additionally, Giorgi (2008) pointed out the researcher utilizes phenomenological methods throughout the study, including interpreting the results. All members of a study are likely to not be educated in the methods of phenomenology and are therefore unqualified to verify the results of such an analysis and interpretation (2008). Giorgi (2008) also believed it is not trustworthy to allow participants to perform member checks as a verification of validity. Further, clarification of the results is for the sake of the discipline of nursing, not for the sake of the individual participants; meanings are derived from the analyses of the individual

experiences in the final interpretation (2008). However, in my study, participants were asked for verification of meanings of responses during the interview process, enhancing the trustworthiness of the findings.

Transferability was the second means of establishing trustworthiness in this qualitative study (Lincoln & Guba, 1985). Transferability is the degree to which a study's conclusion can be transferred to similar contexts. To allow others to judge the transferability of the findings and interpretations of this study, the researcher collected a data base of thick descriptions compiled of a broad range of relevant, informative descriptors contributed by a purposive sample of participants with direct experience with the phenomenon of interest (1985).

Dependability and confirmability were the third and fourth means of establishing trustworthiness in this qualitative study (Lincoln & Guba, 1985). A demonstration of confirmability established dependability and was achieved by creating an audit trail and maintaining a reflexive journal during data gathering and analysis (1985). The researcher recorded reflections about methodology made during the phases of data gathering and data analysis in a reflexive journal (Streubert & Carpenter, 2011). Finally, the researcher's data analysis and interpretations were confirmed through triangulation with the dissertation chair to ensure the interpretations of this study were credible (Lincoln & Guba, 1985).

Limitations

Human beings were the source of data for this qualitative study which can create a limitation in several ways. I assumed the participants actually experienced incivility within the context of clinical education in hospital settings and were telling the truth about their encounters to the best of their recollection. An attempt to strengthen this limitation included asking participants about encounters with incivility in the clinical education setting that had occurred within the past year, however, participants described experiences occurring more than one year prior to being interviewed. Another limitation human beings bring to qualitative studies is the potential for a lack of clarity when explaining or describing their feelings and experiences, however, participants' descriptions were understood and required no additional contact to obtain clarification of meaning.

Inexperience of the researcher with qualitative interviews was a limitation, thus, the researcher conducted practice interviews. The chair reviewed the transcribed interviews and provided feedback prior to the conduction of additional interviews. Additionally, the dissertation chair provided guidance throughout this qualitative inquiry.

An additional limitation was the small sample size of this qualitative study which lacked gender diversity. Only one male participated. Further, the small sample size may

not be reflective of the perceptions of larger populations, therefore, the findings should not be generalized to all populations.

Summary

This chapter explained the qualitative methodology for this descriptive phenomenological inquiry. This method helped to provide an understanding of what it was like for registered nurses to encounter incivility during the clinical education of nursing students. Procedures for sampling and data gathering were explained and the data analysis process was delineated. Additionally, the processes of obtaining informed consent and maintaining confidentiality were described. Finally, the steps to establish trustworthiness and rigor were outlined and the limitations to this study were explicated.

CHAPTER 4

PRESENTATION OF FINDINGS

The findings of this descriptive phenomenological study of registered nurses' experiences with incivility during the clinical education of nursing students within hospital settings are the focus of this chapter. First, an explanation of data management and data analysis is presented. This is followed by a presentation of the themes and subthemes that emerged from the participants' descriptions. This presentation is supported with quotes from participants' descriptions of their lived experiences.

Data Management

Original approval from the institution review board (IRB) of Mercer University sought to include registered staff nurses who had encountered incivility with nursing students on medical-surgical units. This approval also included inviting these nurses through a hospital-dispersed email to target these specific nurses. However, the researcher encountered difficulty accessing all intended hospitals for this study's purposes. A representative from one facility stated that nurses have to answer questions from multiple sources too often and an individual from a second hospital cited not wanting to be a part of a "study like this." Therefore, the application for IRB approval was modified and resubmitted; approval was granted for inclusion of any

registered nurse who had encountered incivility with nursing students during clinical education within hospital settings.

After obtaining IRB approval from Mercer University for the modification, informed consent was obtained before interviews were audio recorded digitally. These recordings were available only to the researcher, the dissertation committee chair, and a transcriptionist. A contract with a professional transcription company was established and included maintaining the confidentiality of the digital files that were uploaded to a secure server via the company's password-protected website and/or application for access by a transcriptionist. Each interview was typed verbatim by a transcriptionist into a Microsoft Word document which was sent to my electronic mailbox. Upon receipt of the transcribed Word document, it was downloaded into a document file on my password-protected computer and then to an external hard drive. A total of 14 interviews were audio-recorded, only 13 were analyzed as explained later in this chapter. I listened to each interview while simultaneously reading the transcribed interview to verify accuracy of the participants' responses and to ensure confidentiality within the descriptions. No identifying information was included on the verified transcribed narratives. As this process was completed for each transcript, a copy was sent to the dissertation chair's electronic mail and a copy was printed that allowed me to manually code the data.

Confidentiality was maintained throughout this process by using participant-selected pseudonyms. Further, if participants mentioned specific names of people during the recorded interview, I redacted the name and replaced it with a pseudonym of my choice. If participants named an institution during the interview, the name was redacted and replaced with the word "hospital" and a random letter to indicate the discussion of different institutions by the same participant. All printed documents and audio files were stored in a locked container and accessible only by the researcher. All electronic files were stored on a computer and external hard drive that were password-protected.

Data Analysis

Data analysis was conducted to answer the research question: What experiences with incivility have registered nurses encountered during the clinical education of nursing students in hospital settings? The dissertation committee chair and I communicated throughout the data analysis process. After each interview was completed, the verified transcribed narratives were formatted in Microsoft Word for the researcher and the committee chair to perform manual first and second-cycle coding. To enhance rigor of this qualitative study, the researcher and the dissertation chair separately performed manual coding using first and second-cycle coding methods as delineated by Saldaña (2013). The individual codes were discussed followed by the identification of themes and subthemes.

Giorgi's (2009) process for data analysis was implemented throughout analysis of the data. Each transcript was read as a whole, in the order the interviews were conducted, to gain an understanding of the participants' descriptions. Meaning units were derived from the participants' rich descriptions. Saldaña's (2013) first-cycle coding method of the data was implemented for the transcripts and included the use of descriptive, in vivo, and versus coding. First-cycle coding was followed by second-cycle coding as delineated by Saldaña. Data were collected and analyzed over a five-month period of time. Three themes and sixteen subthemes emerged from the data analysis process.

Coding

First-cycle coding was used to apply codes that captured the essence of the meaning units of all valid transcripts, which allowed for comparison of each participant's experience with incivility. Second-cycle coding was used to categorize and refine the initial first-cycle coding results. Focused coding, as a second-cycle method, was selected because it is appropriate for categorizing the data in order to facilitate the identification of themes and subthemes in descriptive qualitative studies by the process of assessing the "comparability and transferability" (p. 217) of collected data (Saldaña, 2013).

First-cycle coding began after reading the transcribed transcripts to get a sense of the whole. As the verbatim narratives were read a second time, I manually noted a short description in the margin that described the meaning units selected from within each participant's description. In vivo and descriptive coding were used initially, but

versus coding was added during the first-cycle coding of the second interview when dichotomous groups were being compared by the participant.

Patterns in the first-cycle codes began to emerge after eight interviews had been analyzed. At this point, second-cycle coding was implemented to capture analytic memos and to begin categorizing the data. Focused coding was used to develop categories for the data corpus and to help guide the remaining data collection process. Based on the developing categories of data, additional interview probes were developed that assessed comparability of these categories (Saldaña, 2013). These new interview probes were utilized in the remaining interviews.

These coding methods allowed for themes and subthemes to be derived. A description of these themes and subthemes resulted from the inclusion of verbatim participant descriptions and from collective descriptions taken from all transcripts. These themes and subthemes established the structure of experiencing incivility during the clinical education of nursing students.

Discussion of Findings

Demographic data were collected to describe the sample and to enhance the descriptions of the participants' lived experiences with incivility encountered with nursing students during clinical education in hospital settings. The demographics of the registered nurses who participated in this study included age, gender, length of time as a registered nurse, years of experience as an educator, and the highest level of nursing education attained. These demographics are presented in Table 1.

Table 1

Participant Demographics (N=13)

Demographic	n	Range	Mean
Gender: Female	12		
Male	1		
Age of participants		29 years – 63 years	44.7 years
Length of time as a registered nurse		7 years – 40 years	21.5 years
Years of educator Experience		2 years – 35 years	10.6 years
Highest level of nursing education			
Associate's	1		
Bachelor's	2		
Master's	7		
Doctorate	3		
DNP	1		
Ph.D.	2		

Fourteen respondents were interviewed; however, only 13 participants' demographic data and their verbatim transcripts were analyzed and included in the reported findings. The interview and demographic data for participant number three were excluded. During the analysis of this participant's transcript, the researcher determined the participant had not met the inclusion criteria of discussing an

experience with incivility that occurred during the clinical education of nursing students. Instead, the participant discussed a civil experience with a new graduate nurse whom she was orienting to the nursing unit. Therefore, the researcher and the dissertation committee chair decided this transcript should be eliminated from the data analysis process and subsequently was not included in the presentation of findings.

The characteristics of participants' clinical settings and work experiences included the type of clinical units in hospital settings in which incivility was experienced as well as the role of the registered nurse, which met the purposive sampling plan. These characteristics are presented in Table 2. Work experience as a preceptor or as clinical faculty, most recent uncivil encounter, and number of uncivil encounters in hospital settings during their careers are also included in Table 2. The male participant spoke from his experience as a director of nursing in the administration of a hospital while also including his experiences as a clinical faculty. It was remarkable that all participants had experience educating nursing students either as a preceptor or a clinical faculty.

Table 2

Characteristics of participants' clinical setting and work experience

Descriptor	Total Number (n=13)	Range	Mean
Type of clinical units:			
Medical-surgical	8		
Stepdown unit	2		
Intensive care unit	2		
Urgent care	1		
Registered nurses' role on clinical unit:			
Staff nurse	4		
Preceptor	7		
Clinical faculty	1		
Administrator	1		
Worked as a preceptor	5		
Worked as clinical faculty	8		
Most recent uncivil encounter months		0.25 months – 132 months	25.3
Number of uncivil encounters in hospital settings during career		3 encounters – 30 encounters	8.2

Thirteen descriptions of registered nurses' experiences with incivility were analyzed. Participants' experiences and most recent encounters with incivility occurred within the southeastern United States prior to or within 2017. Participants experienced incivility while fulfilling different roles. Two participants were preceptors for nursing students who were in their final semester of a nursing program. Three were staff nurses

on nursing units who had at least one of their assigned patients concurrently assigned to a nursing student. Seven participants were clinical faculty and one was a director of nursing at a large hospital in the southeastern United States, who also served as clinical faculty.

Analysis of the data resulted in the identification of three themes: *influences on uncivil actions, experiencing and responding to incivility, and aftermath of incivility*. A total of 16 subthemes emerged from participants' rich descriptions. The strongest theme was *experiencing and responding to incivility*, as this theme described what it was like for registered nurses to encounter incivility in hospital settings and how they responded to these experiences. These three themes and their subthemes will be discussed with illustrations and examples provided by verbatim quotes from the participants as support for these themes.

Theme One: Influences on Uncivil Actions

A significant theme to emerge from the registered nurses in this study was *influences on uncivil actions*. This theme captured registered nurses' feelings of stress and frustration from which incivility emanated, leading to hostile work environments and negatively affecting the clinical education environment of nursing students. Within the theme *influences on uncivil actions*, a large number of contributing factors that influenced uncivil actions within clinical education environments were revealed. These contributing factors were categorized into the following subthemes: *demographical influences, organizational and environmental influences, educational and professional*

influences, and physical and psychological influences. Each subtheme will be described and supported by verbatim quotes from the 13 registered nurse participants and will include comparisons and contrasts to relevant literature.

Subtheme: Demographical influences. The subtheme *demographical influences* was supported by the elements of *male versus female* and *"a generational problem"* which explained how differences in gender and generations influence uncivil actions. *Male versus female* elucidated how perceptions of gender differences influenced participants' perceptions of the frequency and prevalence of incivility and determining behaviors as civil or uncivil. Participants also discussed the effect of female dominance on the nursing profession. The element *"a generational problem"* captured the different perceptions of uncivil actions between older nurses and younger nursing students, including student entitlement and the use of personal technology. These findings were not consistent with reports within the literature review for this study, as presented in Chapter Two; nor have recent studies found a correlation between incivility or bullying with age or gender in the context of this study (Anthony, Yastik, MacDonald, & Marshall, 2014; Wieland & Beitz, 2015). Additionally, neither gender nor generational differences were supported by the conceptual model for fostering civility in nursing education, as adapted for nursing practice, by Clark and her colleagues (2011).

An unexpected finding from almost half of the participants was the element of *male versus female*. Within participants' descriptions of their interactions among males and females, two distinct gender differences were revealed. The first difference

revealed was a greater occurrence of incivility among female registered nurses than male nurses. Female nurses in stressful situations on medical-surgical units took their coworkers' actions personally subsequently responding emotionally rather than professionally. A national study (*n*=1008) by the Workplace Bullying Institute (2017) found 67% of females bullied other females while 35% of males bullied other males in the workplace. Jan described working with females on a medical-surgical nursing unit, "There's the female-to-female thing. . . . That snippy female thing that occurs sometimes when you have a lot of females around each other. There's something about how we relate to one another that can be very mean and ugly." Melanie contrasted what it is like to work with males versus females when she stated, "I've always enjoyed working with male nurses, either as a faculty member or as a staff nurse, because they're not catty. They come in, they work hard, they do their job, they go home."

Overall this study found males exhibited incivility less frequently than females, which is contrary to a study of full-time workers in various job roles by Gallus, Bunk, Matthews, Barnes-Farrell, and Magley (2014), who found men were more likely to engage in incivility than females. However, stressful work environments within which registered nurses work can level this field of influence (Gallus et al., 2014). Jan pointed out what can cause male nurses to exhibit incivility as equally as female nurses:

> Just overworked and angered and frustrated. Pretty much the same reasons [as females]. . . . You can't stop moving. You can't get done. You can't finish what you need to do without having a hundred other interruptions trying to finish something else.

The organizational context in which incivility takes place can cause males to exhibit uncivil behavior (Gallus et al., 2014).

The second difference among genders was how behaviors were perceived. Some participants indicated males did not perceive incivility in the same behaviors females deemed to be uncivil. Jan's description illustrated this difference well: "If you're very rushed and you're snippy, a guy would be like, 'She's busy,' where a female will be like, 'Why are you being such a b [bitch]?' . . . . Their [males] take on it is different." The only male in this study was Joe, participant number 13, who had forty years of nursing experience. I specifically asked him if he had ever noticed a difference in the perception of incivility between males and females. He responded, "I personally can't say that I've seen a difference where that females acted one way and males acted differently." A study (n=173) to determine if nurse faculty (n=14) and nursing students (n=159) have a difference in perceptions of incivility found no significance difference between gender and the occurrence of uncivil behavior (Aul, 2017).

With nursing as a female-dominant profession, it follows that nursing units where clinical education takes place is likely to consist mostly of female nurses. Therefore, incivility is likely to be present in these female-dominant nursing units where nursing students are present. In the detailed accounts of experiences with incivility in my study, females perpetrated incivility 40% more than males. Perpetrators of incivility included 15 females (nine were nurses and six were nursing students); and six males (one was a nurse and five were nursing students). Targets of incivility included 18

females (14 were nurses and four were nursing students) and three males (one was a nurse, one was a nursing student, and one was a patient). These findings are consistent with a peer-reviewed literature review of bullying and harassment of medical students by Jamieson, Mitchell, Le Fevre, and Perry (2015). They concluded that bullying is "profoundly gendered" (p. 464) where men and women encounter different types of workplace bullying, however, females were more likely to experience gender incivility. No studies within this study's context could be found in the nursing literature.

Another demographical influence on uncivil actions was found to be *a generational problem* for five out of 13 participants. In the current study, generational differences influenced uncivil actions from the frustration of registered nurses who perceived younger nursing students as "unconcerned with being there." This study found older generations of nurses perceived younger generations of nursing students as disrespectful and unable to disconnect from personal technology, causing concerns for patient care. Generational differences regarding disrespectful behaviors negatively affected clinical education experiences because nurses did not want to work with nursing students who they perceived as "lazy, or uncaring, or uninterested."

Registered nurses in the current study perceived nursing students as disrespectful when they presented an unprofessional appearance, put themselves before others, or used inappropriate verbal behaviors toward clinical faculty. Jennifer, a clinical faculty, talked about respect when I asked her about the influence of the *Code of Ethics for Nurses* on incivility, she responded:

> I think it's a generational problem. . . . As far as respect, respect your elders. And this generation doesn't understand some of those codes of ethics, just don't understand respect. . . . They don't understand the concept of respect and respecting adults.

The unprofessional appearance of a nursing student in his final semester of a nursing program was described as disrespectful by Rose, a clinical faculty: “I had a student who . . . seemed to be disrespectful towards me in general. When he first encountered me he had dirty fingernails, unkempt clothes, smelled like smoke, and I felt like it was just an unprofessional appearance.” Jennifer described the inappropriate verbal behavior of a clinical student who was not happy about her clinical assignment as being very hostile, said a few choice words, and body language wasn't appropriate.”

Inappropriate use of cell phones influenced uncivil actions for nurses in this study. The students’ behaviors demonstrated a lack of respect for authority figures such as clinical faculty. Carrie pointed out how younger generations’ use of technology influenced uncivil actions and was a cause of concern for the future of patient care:

> They are so attached to social media and technology that they can't do a job without . . . they can't spend eight hours taking care of a patient without being connected on social media or to the outside world. So, I found it very aggravating and I felt like it was disrespectful for the patient and for myself that they weren't providing the best care.

Inappropriate use of technology negatively affects teamwork and collaboration (Walrath, Dang, & Nyberg, 2010). Carrie’s statement summarized this subtheme: "I think this generation is just inconsiderate and, on their phones, and they don't consider that disrespectful." Nursing students in Hilbert’s (1985) study disagreed about unethical

clinical behaviors. Over 30 years later, nursing students consider cell phone use "commonplace and harmless" (McNally, Frey, & Crossan, 2017 p. 5), demonstrating a continuance of generational differences regarding perceptions of disrespectful behavior.

The overall degradation of American society was cited as a cause of disrespect among the younger generation of nursing students, partially attributed to influences from social media. Alaina offered this insight:

> I feel like it's not only in nursing with incivility, but it's our societal inability to wait our turn and listen to the thoughts of others, even if we disagree. We are now shouting at each other to try to show how we are right, and we've lost that ability to just treat each other with respect.

Walrath and her colleagues (2010) suggested the increase of incivility in American society has crossed over to nurses' work environments.

Another generational difference revealed in this study that influenced uncivil actions was student entitlement. This finding aligns with Clark and colleagues' (2011) conceptual model, identifying student entitlement as a contributing factor to stress in nursing education. Both clinical faculty and preceptors described students as entitled who undermined authority, behaved as though policies did not apply to them, felt they could determine their clinical day activities, or mocked clinical documentation assignments. An example of undermining clinical faculty authority was provided by Jennifer. After experiencing incivility from a nursing student at the beginning of a clinical day Jennifer said, "The student reported to the dean that I embarrassed her in front of her peers." Jennifer discovered she had been reported to the school's dean by

the student after receiving a telephone call from the dean while still on the clinical unit. Jennifer noted the "dean tends to favor the student, so I was sort of guilty before proven innocent." This made Jennifer feel "betrayed and not supported."

Carrie described a precepting nursing student who would not stop using her telephone at the nurses' station despite her assigned patient needing care. "For the staff, we were not to have cellphone usage at the nurse's station. . . . But the nursing students felt entitled." Jennifer's statement summarized the influence of student entitlement on uncivil actions: "I think that as students feel entitled, that sometimes it can increase that incivility." The findings in this subtheme are congruent with nurse faculty in Clark's (2008b) study who regarded attitude of entitlement, the misuse of cell phones, and text messaging as student incivility.

The importance for all generations of nurses to work together in confronting the problem of incivility was revealed in this study. Melanie highlighted this issue:

> Incivility is really holding back the profession on so many levels. I'm not sure how we can cure incivility, but we have to find a way to work through it and try to do a better job with the next generation of nurses because I don't think we can advance our profession unless we can work on incivility.

The nursing literature is replete with studies on the generational differences among practicing nurses, nurse faculty, and nursing students, but as Ziefle (2018) concluded in her quantitative study on the influence of generational differences on incivility in nursing education, "incivility in nursing education continues to be a significant problem" (p. 30) facing all members of nursing education.

Subtheme: Organizational and environmental influences. Incivility occurring during the clinical education of nursing students was found to be influenced by a host of organizational and environmental sources. This finding was congruent with the conceptual model by Clark and her colleagues (2011) who found volatile conditions within organizations as contributory to stress within nursing practice. Participants described how the economic implications of nursing practice and a lack of administrative support influenced uncivil actions within nurses' work environments. Additionally, nurses described the "struggle for real estate" in hospital settings while nursing students were present for clinical education.

One element of organizational influence on uncivil actions of which participants lamented was the economic implications of nursing practice. Economic implications included striving for good patient satisfaction scores, working with a lack of adequate supplies, and less than adequate staffing. Registered nurses were frustrated by the difficulty of ensuring safe, high-quality patient care when they lacked adequate resources such as human, equipment, and patient-care supplies. These findings are consistent with Walrath and her colleagues (2010). The conceptual model by Clark and her colleagues (2011) indicated a lack of human and financial resources contributes to adverse relationships between nurses employed in hospitals and clinical faculty. Ironically, when hospitals do not invest in adequate supplies and equipment for patient care they stand to lose billions of dollars each year due to the turnover of nursing staff (Nikstaitis & Coletta Simko, 2014).

A lack of equipment and adequate supplies was a source of frustration and incivility for participants. Hospitals with limited resources created contention among nurses who were vying for coveted pieces of equipment as also found in a study of hospital workers (Hamblin et al., 2015). This situation was worsened when nursing students were present on nursing units. Jan illustrated how the lack of equipment created hostility between nurses:

> If you don't have what you need, that's very frustrating. . . . Not having enough IV pumps for the hospital so that the nurses are fussing with each other. . . . They [administration] created that little animal there where the nurses are hostile to each other.

Joe illustrated another way a lack of equipment influences uncivil actions when he stated, "There might be more incivility with people, perhaps hoarding and hiding, those kinds of things." The lack of equipment in hospitals is not unusual and has been found to cause counterproductive work behaviors as well as interpersonal aggression among workers, which stemmed from anger and frustration (Hamblin et al., 2015).

A lack of resources can impact registered nurses through patient satisfaction scores. These scores affect staff nurses' employee evaluations which are linked to how satisfied patients were with their care. Additionally, lower patient satisfaction scores meant less financial reimbursement from insurance providers for the patient care provided by hospital staff. Jan explained it this way: "You're gonna *[sic]* end up with less money to buy things that you need for your patients in the hospital setting because your reimbursement's gonna *[sic]* be lower." Jan revealed being scored by patients caused

her to feel increased “frustration and anxiety.” Joe presented the position of most healthcare institutions, “Let’s do more with less. . . . Let’s do more, let’s do it faster, let’s do it quicker, let’s do it more economically with less. Less people, less supplies, less equipment, less time, and so forth.” However, adequate resources must be available to nurses in order to provide quality patient care (Ducharme, Bernhardt, Padula, & Adams, 2017).

Other economic implications influencing uncivil actions were inadequate staffing and nurse turnover, which were prominently identified by participants as stressors. Due to being one of the largest organizational expenses, nursing resources are the easiest to adjust (Ducharme et al., 2017). Reducing registered nurse staffing can lead to difficult workloads which can increase nurse turnover. Myra pointed out how “adequate staffing” is needed to provide a safe ratio of assigned patients to nurses to accommodate safe, quality patient care. Referencing an oncology unit, Myra suggested nurses should tell administration, “We have high acuity patients, you can’t have three out of your six patients receiving blood products and the other three receiving chemo and expect this to be done safely. So, we’ve got to have enough staffing.” I asked Myra how the understaffing of her nursing unit created incivility. She responded, “I didn’t stick around long enough to find out. It’s just complete turnover all the time.”

The organizational and environmental pressures felt by participants contributed to perceived lack of administrative support and was found to influence uncivil actions. Participants were not explicitly asked about the administration of their employers, yet

11 out of 13 registered nurses offered mostly negative perceptions of administrative support. Disruptive behavior can be triggered by stress from a lack of support (Walrath et al., 2010). The members of administration discussed by participants included nurse managers, directors, and house supervisors within hospitals and directors, deans, and chairpersons within educational facilities.

Unfortunately, a majority of the registered nurses in this study described a lack of support from administrators in both hospital and educational settings. As explained in Chapter Two, a lack of nurse manager support was found to result in staff nurse incivility (Walrafen et al., 2012). These negative perceptions arose from issues with understaffing, favoring students over faculty, nurse hostility, and not holding employees accountable for unprofessional behaviors. Some participants perceived these issues were poorly handled because of politics among administrators.

A few participants in this study referred to their hospital administration as a "sorority," to indicate the political nature within these groups. Myra described a hospital's administration where she was once employed as "quite the little sorority group of nurses." She illustrated her perception by contrasting two nurse managers. She described a female nurse manager:

> I worked on a med-surg floor where we never had less than eight patients; and you cannot take care of a GI bleed, and an overdose, and whatever else was coming through the door and have med time at 8 o'clock in the morning and have all of this stuff done safely with eight patients. That's just an absurd expectation. And that was how she always staffed this unit. Despite all of our cries for help that the acuity was too high to have that number of patients and provide nursing care.

She compared this experience to the practices of a male nurse manager:

> He didn't play the politics game with them. He stood up for his staff. He stood up for his patients. He was less concerned with understaffing to increase his own money. He always staffed in favor of patient safety and patient care.

Myra revealed the consequences of these managers' decisions, "She always looked great. She's still a nurse manager. . . . He ultimately paid the price because people didn't like him." She explained her perception of how the male manager was treated differently:

> He didn't fit in so well with all of these ladies and these were all of the directors of the units. . . . They restructured his unit and he lost his title. He was able to keep his job, but they essentially buried him under the hospital. He moved from being a director of his unit to just being part of sterile processing.

Trudy related this "sorority" mentality to the selection of preceptors who educate nursing students immediately before graduating from nursing school. Unfortunately, Trudy's statement underscores how this dangerous tactic influences uncivil actions: "They don't choose people who have patience, character, can handle pressure. I don't think they always choose the best people. . . . I say they choose because of they *[sic]* friends." Likewise, Melanie provided a rich description of a perpetually uncivil nursing assistant who became a staff nurse with whom no one wanted to work and had to frequently change nursing units due to his incivility. Despite his uncivil behavior, he continued to be employed at the same facility. Melanie stated her perception as to why he was not held accountable for this behavior, "He's married

to somebody that's in administration, so he of course gets little special privileges." What she said next was the most concerning for how unsupportive administrations influence uncivil actions, "He's one of those that buddies up with administration, but not does work well with his colleagues. That's what I do see sometimes from the uncivil nurses is that's how they get away with what they do." This example is in direct conflict with existing Joint Commission (2008) requirements to "create a culture of safety by creating an atmosphere of trust and fairness that encourages reporting of risks and adverse events . . . especially in relation high-risk or problem-prone processes" (p. 2).

A lack of administrative support was perceived by clinical faculty who had to manage uncivil nursing students. Faculty in this study perceived a lack of administrative support when they were misguided by administration or did not receive support for decisions made during clinical education in regard to uncivil nursing students. Luparell (2011) discussed how nursing faculty who "deal assertively with uncivil nursing students" (p. 94) in the clinical education setting are challenged due to a lack of administrative support, particularly when the student is otherwise performing adequately. Myra went through a lengthy ordeal with a nursing student who had perpetrated incivility against her during clinical education. She "didn't feel supported" because she was "not guided properly through this [situation] by our director at the time." This resulted in reduced consequences for the uncivil student's behavior whereby he was able to continue his nursing education elsewhere and ultimately graduate.

Some clinical faculty described how administrators have increased nursing students' sense of entitlement by undermining the authority of faculty student evaluations. Jennifer described how nursing students were able to manipulate school administrators in order to get what they wanted: "For them reporting you to administration and administration makes changes either to the assignment or to a clinical instructor, it would give the student a sense of entitlement if they feel that they have control over what happens." Administration must support faculty's strict evaluations of uncivil nursing students to prevent its perpetuation (Luparell, 2011). Jennifer felt the dean was "undermining my authority and making decisions without asking my input. There was a lot of incivility among the staff with the dean." When confronting unethical behaviors like incivility, faculty must be united (Hilbert, 1985). A lack of administrative support can increase faculty stress, increasing the influence for uncivil actions (Clark & Springer, 2010). Ultimately, Jennifer perceived the administration of the school "wanted to get rid of me." Administrators of nursing education have the responsibility of creating and maintaining a civil and respectful work environment where perpetrators of incivility are held accountable (Clark & Springer, 2010).

A lack of administrative support was described from the perspective of staff nurses. Participants expressed concern that administrators were no longer in touch with nursing practice in clinical settings. Jan described this perception when she spoke about her desire to just be able to nurse at the bedside:

> There's a total loss of understanding what nurses do. . . . Even though they are nurses, I don't think they understand what nurses do anymore, and I don't know why that is. Maybe they never did med-surg nursing or maybe it's been such a long time ago that they don't understand how the acuities have changed now. . . . I really don't understand why the bureaucracy is just what it is.

Coursey, Rodriguez, Dieckmann, and Austin (2013) reported administrators who are not involved in the daily activities of employees will be less effective at managing disruptive behaviors in the workplace.

Administrators also influenced uncivil actions by not holding staff members accountable for unprofessional behaviors, such as frequent "call-ins." Myra described an example of how staff nurses feel when their colleagues behave unprofessionally without consequences:

> When you can count on so and so to call in on their third day for that week and that's documented, but then administration isn't going to do anything about that, that's also frustrating. Nobody wants to work with that person when they're there because they don't like them. They're not a trustworthy person.

Elizabeth's statement contributed to understanding why these unprofessional behaviors continue:

> They'll just stay in their [managers] office and let things happen as they may on the floor. . . . I think managers have to walk a fine line, and a lot of times they just would rather let it play out and blow over than they would to get in the middle of something where they might actually have to do something about a problem.

A consequence of an unsupportive administration noted by Joe is the creation of "an environment where . . . you don't really feel the level of support from the

administration, from the organization, to do your best job and to care for the patients as you know they should be cared for." When administrations fail to address staff members' concerns, horizontal violence can result when employees attempt to address the situation on their own (Walrafen et al., 2012). Administrators who ineffectively address disruptive behaviors worsen lateral violence (Coursey et al., 2013).

Another element of organizational influence on uncivil actions described by participants was "*a struggle for real estate"* during the clinical education of nursing students in hospital settings. Nurses described their frustration of having a lack of available work space at their nurses' stations while students were reviewing patients' medical records. Jan described how this problem led to incivility:

> They're [nursing students] in your work area where you're trying to sit down and look at a chart real quick. . . . They [the organization] really don't make room for them to be there, so you are at a struggle for real estate with a nursing student to get what you need to get done. . . . You get up for a second and you walk by and there's somebody in your seat, you're like, 'I've gotta *[sic]* finish this.'

Participants further described being frustrated by a lack of space in the breakroom for eating lunch or taking a break when students were participating in clinical conferences before or after their patient care experience. Jan illustrated how this issue can influence uncivil actions:

> I went into the break room with my food, finally got time to go eat . . . and walk in the break room to sit down . . . there's nowhere to sit to eat. The students are everywhere. . . . I might've looked around the room with a scowl on my face. . . . You're trying to find just a place to eat. There's no place for students in the work environment. There's nowhere.

> Clinical faculty also encountered negative attitudes from staff nurses about nursing students using the break room as Charlotte described, "Students were not allowed to go in the break room if she was in the break room. . . . Students had their stuff in the break room."

Subtheme: Educational and professional influences. A myriad of influences on uncivil behavior stemming from both educational and professional sources were revealed by the registered nurses in this study. Educational influences on uncivil actions included a collection of the elements *clinical education environments* and *"Where did you go to school?"* Professional sources included the elements of *medical-surgical nursing versus nursing on other units, "utopia academic nursing" versus "real world," and "nurses eat their young."*

A convoluted element of educational influences on uncivil actions was *clinical education environments.* Incivility in the clinical education environment was influenced from many sources of stress, including nurses' work environment, nursing students, clinical faculty, and the high-stakes pressures of nursing education. Clinical education experiences themselves are stressful for different reasons. Hope illustrated this aspect when she stated, "A new environment, the nurse's attitude, the floor's attitude, the patient, the amount of work that they have to do. Both pre and post [clinical experience]. All of nursing education." [laughs]

The presence of nursing students in hospital settings was found to influence uncivil actions during clinical education. Students' lack of experience exacerbated this

influence. Jan alluded to this influence when describing an uncivil encounter between a staff nurse and a nursing student:

> There's a lot of hostility anyways between nurses, especially somebody new coming in. I've seen that a lot, just in between nurses. . . . There's new things that they find, like I didn't know about how you don't do IMs in the hip anymore. A nursing student taught me that. I'm like, 'Oh, really?' People are hostile about that. I like to learn new things, personally, but some people get really hostile about that and feel inferior. They just don't like to be proven wrong. 'I've got all this experience, and you're coming in and telling me' . . . you know?

This finding was not congruent with Clark and colleagues' (2011) conceptual model, but it was congruent with the literature review in which nurses in Amann and Williams' (1960) study appreciated learning about nursing trends from students who arrived for clinical education. However, Jan mentioned the hostility between nurses around new nursing students on the unit. This was a disturbing finding because it provides support to Magnavita and Heponiemi's (2011) report of the perpetuation of violence in the work environments of those educated within hostile work environments.

A source of stress noted by staff nurses was nursing students entering the nurses' work environment without being instructed by their clinical faculty about how to behave on the unit. This finding indicated a need for students to hone effective communication skills with nursing staff as put forth in the conceptual model by Clark and her colleagues (2011). Nursing students apparently were not aware of how nurses physically functioned within their work environments, areas to sit for charting, taking breaks, and appropriate moments to ask nurses questions regarding patient care. As

discussed in the literature review, nurses in Amann and Williams' (1960) study did not appreciate the disruption of their routines, resulting from the presence of nursing students. Rose described her experience with nursing students arriving to her nursing unit, "They're sitting in a clinical group and they just bombard that nursing station." Jan explained the differences she has seen with nursing students arriving to her nursing unit:

> I've seen some instructors . . . did not instruct them at all. They would just come and take up our whole area. . . . I had other instructors that . . . did not do a very good job at teaching their students how to behave on a nursing unit, when it's okay to ask questions and when it's not.

A second source of stress noted by staff nurses was not receiving advanced notice that nursing students would be on the nursing unit during their shift. Clark and her colleagues (2011) found a lack of mutual curriculum planning contributed to adverse relationships between educators and staff. Staff nurses in this study consistently described how they began their shift by listing all their nursing activities for the day. Students usually arrived after nurses had planned their shift which cost the nurses time to factor the students into their planned activities for the day. A lack of communicating to staff nurses was the most prominent reason revealed for this issue. Hope aptly described how this can play out:

> There's a lack of communication . . . faculty going to clinical will try to meet with the nurse manager, the clinical educator, the charge nurse, but I think if it doesn't get filtered down to nurses that you have nursing students this day, sometimes it takes them by surprise.

As a staff nurse, Elizabeth explained how she determined students would be present during her shift:

> We generally know they're coming because their instructor gets there super early. Do you know as a nurse that your patient might be assigned to a student? No. . . . They [clinical faculty] just pick whatever patient that is the best learning experience and go with it.

A third source of stress was related to nursing students' patient assignments. This was usually the responsibility of the clinical faculty who may not have been aware of patient acuity, nurses' workload, or nurses' attitudes. Students are typically assigned to care for patients who help the student achieve certain learning objectives, therefore, clinical faculty may not consider the individual staff nurse when making students' assignments. However, factors associated with staff nurses were found to have many influences on uncivil actions within the clinical education environment. These factors included nurses who did not want to interact with nursing students, had a lack of registered nurse experience, and had a difficult workload. This finding coincides with the conceptual model of Clark and colleagues (2011) that identified staff workload as a major contributing factor to adverse relationships between nursing practice and nursing education. Elizabeth explained how many nurses feel about having nursing students present on nursing units:

> Most nurses . . . when they hear they're going to have students . . . roll their eyes because they think it's going to be extra work, or extra teaching someone. I really couldn't put a finger on all the reasons why people groan when they know they're going to have students. But, they do because I see them do it.

Clinical faculty frequently encountered staff nurses who did not want to interact with nursing students and several reasons were offered by participants. Norah's statement revealed some staff nurses want to focus only on caring for their patients, "Some folks don't want to deal with the students. . . . They have what they need to do. They want to be able to do that." Whereas, Rose's statement revealed staff nurses simply did not want to interact with nursing students at all: "They want to find anything they can to not to have to deal with students that day." Likewise, in a qualitative study discussed in the review of literature, nursing students' experiences with incivility during clinical education included nurses not having time for them during their clinical education (Martel, 2015).

My study found staff nurses who typically do not mind having students with them sometimes do not want to interact with students. The most common reasons were having no time to teach and feeling like their role was a nurse, not a teacher. Nurses described feeling a lot of pressure to complete nursing responsibilities in a limited amount of time, leaving little time for the additional responsibility of educating students. Carrie's pediatric facility requires all registered nurses to be a preceptor to nursing students due to the volume of students and the limited pediatric facilities. She stated, "We are a nurse and not a teacher. And when you're not asked if you want to take on that role sometimes it can be frustrating." Jan alluded to her busy shift work where she admitted she may display unintentional incivility:

> I've been in situations where I've had way too much on my plate, and I really do not have time to teach. I'm like, 'You need to go ask your instructor. I can't help you with that.' Wanting to be bullying or hostile, no. Just like, 'I can't talk to you.'

A moderating effect on the stress of having nursing students present on the nursing units was having extra help with patient care. Most of the nurses in this study, both staff nurses and clinical faculty, perceived nursing students more as helpers than learners. A few nurses believed students' focus should be mostly on learning. Myra offered her perspective as a clinical faculty: "When we're in clinical, they're really needing our hands. They need all hands on deck. They're thankful to have nursing students there. We provide a great help to them." But as Carrie described, some nursing students can influence incivility when they are not engaged in learning:

> When it's a fast-paced environment and this is a nurse [nursing student] that's about to graduate and take the state boards, it can be very beneficial for the staff member to have someone to help; a second set of hands. When they're unengaged it's frustrating to have to keep up with them.

Trudy's statement revealed how relying on unexperienced nursing students for help can lead to incivility:

> You *[sic]* telling her [a student] to do something she didn't know how to do, and you get a little agitated . . . you can't look at them as help. You got to look at them as they're learning.

Trudy further revealed how the nursing shortage may create staff nurses' reliance on nursing students:

> When you get in . . . we're not supposed to say, nursing shortage thing, and you got all these patients, it becomes, "Oh, I got a student today, this

> is going to be somebody to assist me," and they're not. They're there to learn. You missed the opportunity to teach, to show them something.

A fourth source of stress within the clinical education environment that can influence incivility was described by eight participants as being a lack of staff nurse and clinical faculty availability for nursing students. The availability of a knowledgeable resource who possesses competent skills and clinical judgment for a nursing student who is still lacking these qualities is important for student learning but is also important to maintain patient safety. Findings in this study revealed when clinical faculty were not available to answer nursing students' questions or provide guidance, the students sought staff nurses to fulfill this need and were described as frustrated when they could not find their patient's nurse. This finding is consistent with the conceptual model by Clark and colleagues (2011) that explained how limited clinical faculty can contribute to relationship strains with nursing staff. As explained in the literature review, students in Anthony and Yastik's (2011) study encountered incivility when they asked questions of the nurses. Responses from staff nurses in my study provide an explanation for the incivility experienced by students in Anthony & Yastik's (2011) study. Staff nurses in my study felt overwhelmed when nursing students could not find their clinical faculty resulting in them asking the nurses a lot of questions. Jan first noted how "the instructor just kind of disappeared, and the nursing students were just following nurses around."

Some participants explained why clinical faculty, who can have from eight to ten students in a group, may be unavailable to nursing students. The primary reason was workload as noted by Elizabeth, "The instructor can't be 10 places at one time." Faculty were usually present on a nursing unit but not visible to others, such as helping a student with a time-consuming task like medication administration. During the time a clinical faculty is with a student, learning opportunities can present themselves to other nursing students when staff nurses have an order to complete. However, the clinical faculty has to be present with the student for supervision of most of these tasks or skills. Staff nurses were described as having the potential to become frustrated if they had anticipated a nursing student performing a nursing skill for a patient, but the clinical faculty was unavailable to supervise the task as explained by Jan:

> If the instructor had too many nursing students in the environment, he or she would not be available for the students. It definitely would be frustrating if you . . . finally got an opportunity to do a Foley as a student, and your instructor's tied up with two other students doing something else, and he or she cannot go do that Foley, and that nurse is like, 'I've gotta *[sic]* go. We can't wait anymore.'

Charlotte provided a clinical faculty perspective of how an "instructor is pulled in different directions. . . . There is less time of availability. . . . You're not even hardly available." As previously described, many staff nurses view themselves as nurses and not teachers, but as Melanie pointed out when clinical faculty "cannot get to every student" the "staff nurses have to do some of the teaching," which she believes is "good for the students to hear from the staff nurses."

"Where did you go to school?" captured a surprising revelation about the negative perceptions both registered nurses and nursing students have about the different types of entry-level nursing degrees. This influence on uncivil actions was discussed by five participants who were mostly staff nurses. Differences were noted between registered nurses (RN) and licensed practical nurses (LPN), bachelor's of science in nursing (BSN), associate's degree in nursing (ADN), and master of science in nursing (MSN), even doctoral degrees, influencing not only the interactions between students and registered nurses in clinical education environments, but also the decisions clinical faculty made regarding students' patient assignments. Lastly, differing nursing degrees also determined how staff nurses perceived hospital policies. The findings in this subtheme were supported by the conceptual model by Clark and colleagues (2011) in that perceptions of the differences in nursing degrees types negatively affected interpersonal relationships between nurses and students.

Nursing students' negative perceptions of entry-level nursing degrees other than a BSN were described by the registered nurses in this study influencing uncivil actions. Staff nurses perceived they were treated uncivilly because of the type of nursing degree they held. Based on these interactions, they believed nursing students perceived them as incompetent, having nothing to contribute to the educational experience of a nursing student earning a higher nursing degree. Norah described her experience with nursing students who assumed she had an ADN instead of a BSN.

> A lot of people assume . . . everybody's ADN. And we get a lot of BSN students, so they kind of treat you like you don't know what you're doing, or you have nothing to offer us because you're not on the same level of training that we're getting.

She went on to illustrate how students discovered the type of degree she had earned and how this affected students' interaction with her:

> If they have an issue, they'll struggle and then some off conversation, or . . . they'll ask you, "Where did you go to school?". . . You'll be like, "Oh, University A." [a school offering a BSN] then after that . . . I'll notice that, okay, they're asking me all the questions not everybody else because they know that I'm the one here with the BSN degree. That's like, "Okay, that's kind of bad considering that's not my patient."

In the review of literature, Matsumara, Callister, Palmer, Cox, and Larsen (2004) found master's-prepared nurses were more collegial toward students and did not feel threatened.

Perceptions of different nursing degree types by nursing students also affected patient care. Nursing students earning a BSN believed they were exempt from certain aspects of patient care. Trudy described an encounter in which a BSN student: "I had a nursing student who basically told me she don't *[sic]* wipe bottoms because she has a bachelor's."

The data also revealed staff nurses associated certain attitudes and behaviors with different schools of nursing. Norah described the origin of staff nurse perceptions of nursing students based on which school they were attending, "We were getting like four or five different schools coming in. So, you're like, 'Well, we don't like that student from this particular school because this is who they are, this is their attitude." Norah, a

BSN-prepared nurse, dreaded BSN students more than ADN students because they treated her like she was “irrelevant.” However, she also dreaded students in ADN programs because they treated her like she was “just in their way,” mirroring how the BSN students in Anthony and Yastik’s (2011) study also described feeling they were in the way of staff nurses.

Participants also discussed how staff nurses perceived each other differently based on various types of nursing degrees. Perceptions were mostly related to ADN programs creating nurses with superior nursing skills versus BSN programs. Melanie illustrated how these perceptions influenced uncivil actions in her nursing practice:

> Most people that I worked with had an associate's degree, and they went back later in life to obtain it. They were very bitter towards young people that had a bachelor's degree and were always putting down the bachelor's degree, like, ‘I got that IV, and you didn't,’ and ‘I went to an associate's degree program, so the associate's degree program is better because you learn skills, and you don't really learn that in your program.’ Oh, I've heard that so many times through the years, so many times through the years. I just have to kind of bite my tongue and smile and move on.

Melanie intentionally did not respond to incivility with incivility. Her decision exemplified Clark and colleagues’ (2011) model in the way a person can mitigate incivility by choosing how to manage stress. These inequalities associated with importance of degrees can cause “intercollegial hostility” (Ditmer, 2010, p. 10).

Additionally, clinical faculty ascribed decreased student learning to students being assigned to patients with LPNs. Rose was describing registered nurses who did not want to take patients when she revealed her perception of assigning a registered

nursing student to an LPN: “When they get hardened [registered nurses], when they don't want to take on students, yes the learning is decreased because I'd rather sit them with an LPN that is more seasoned than RNs specifically.”

The perceptions of nursing degree types among hospital staff also affected relationships between nursing students and clinical faculty as well as patient care. Charlotte found the lack of respect of different roles saddening:

> It just brings to mind how sad it is that we don't care for each other. There's a supposed to be a level of respect only because I'm in the role I'm in and students are in the role they're in. It doesn't make me think I'm better than them, but there is a certain amount of respect just because of our roles.

Myra’s statement described how educational influences on uncivil actions affects patient care:

> Patients ultimately suffer if your nursing team does not work together. . . . I don't care what degrees I have, I'm not too good to empty the trash. I'm not too good to wipe somebody up. I'm not too good to help someone cause that's what I signed up to do.

“Nurses eat their young” was an element of professional influences on uncivil actions illustrating a purposeful lack of interaction with nursing students, impatience with those with lesser experience as well as negative attitudes of staff nurses. Some participants used the phrase *“nurses eat their young”* when describing the rude behaviors nurses exhibit toward those with lesser experience. Elizabeth believed using the phrase *“nurses eat their young”* was the best way to describe nurses’ “negative attitude” and their “notorious reputation for not having the patience to put up with

teaching somebody that doesn't have the experience that they do." Research has shown less experienced nurses are often the target of incivility (Ditmer, 2010).

I asked both Carrie and Elizabeth how they define *"nurses eating their young."* Carrie responded:

> Just overwhelmed with patient care and don't want to take students, don't want to explain things, don't want to take the time to explain things or assist the student with doing procedures. I think sometimes seasoned nurses just forget that we were once students.

Referencing the stress nurses feel from working on a clinical unit, Elizabeth responded:

> To have somebody that's new and doesn't really know what they're doing, people just either don't have time to teach them, they don't have the personalities to want to teach them, and they don't have the ability to slow down and stop and help them. A lot of nurses have attitudes where they think they know everything, so they don't want to learn. I think that makes older nurses just have an attitude in general towards students or younger nurses, and they just don't want to teach them because they don't think they will learn, which is not always true.

The behaviors associated with *"nurses eat their young"* both arise from and contribute to stress in nursing practice by the ineffective interpersonal interactions involved as illustrated by the conceptual model by Clark and colleagues (2011). Rose initially said she disagreed that nurses eat their young, however, she described registered nurses who did not want to interact with nursing students as "colder hearted" and "hardened," noting how they were untrusting of nursing students until students proved otherwise. In the review of literature, staff nurses' mistrust of nursing students had negative effects on students' confidence and well-being (Anthony & Yastik, 2011; Martel, 2015; Thomas & Burk, 2009).

The most significant explanation for why nurses eat their young was a difference in the amount of practice experience. All participants discussed the experience level of staff nurses related to uncivil actions. Carried noticed seasoned, experienced staff nurses "are impatient with new nurses." Experienced staff nurses were described as impatient when inexperienced, new nursing students and registered nurses, who also lacked confidence, took longer to complete tasks, made more mistakes, and exhibited more anxiety. Joe described how experienced nurses eat their young when he recalled his experience as a nursing student:

> A lot of the staff probably were somewhat bullying, and I think that's sort of what people think about now when you hear incivility in clinical practices, that there's the bullying or the prodding of another individual, making the younger, less experienced people go through a rite of passage to get their experience, because that individual may feel that they have already gone through that themselves, so they're putting another person in that kind of situation.

Seasoned nurses often use intimidation and demeaning behaviors toward those with less experience, such as new graduates or nursing students, as a "rite of passage" (p. 10) into the nursing profession (Ditmer, 2010).

Notwithstanding, new registered nurses were found to eat their young as well because of their inexperience. Trudy agreed that experienced nurses eat their young, but she described inexperienced nurses as the most likely to perform this behavior:

> It's a combination but mostly . . . new nurses. . . . Because they're not strong themselves. . . . The newer ones are the ones who have the bigger struggles with students. . . . They're trying to create that balance being able to do what needs to be done and then get the student involved too.

Nurses who eat their young either did not want to engage with nursing students or in so doing created a poor learning environment. Nursing students were described by clinical faculty as feeling unwelcomed on nursing units where nurses did not want to incorporate them into the nursing care of patients. Students in Thomas and Burk's (2009) study felt unwanted and ignored when staff nurses did not welcome them. Hope explained how her students felt after experiencing nurses who eat their young:

> Nurses that are not willing to work with a student or not willing to show them what is what while they're performing care, or while they're doing care with their patients, they [nursing students] get the sense almost that the nurse just doesn't like them there, nurse doesn't want them there.

Likewise, BSN students in Anthony and Yastik's study (2011) described nurses as "unhelpful and unavailable" (p. 142).

The most prominent description of how nurses eat their young was nurses' attitudes toward having students assigned to them for the purpose of precepting or assigned to a patient who had a primary nurse assignment. The majority of participants described nurses who did not want to take students. Jennifer's statement revealed the frequency of encountering nurses who do not want to have a nursing student assigned to them or their patient:

> If clinical was twice a week . . . there's always that one nurse on the unit that you know has told you they prefer not to have students. . . . And when they tell you they don't want *[sic]*, you don't investigate. You just say okay.

Melanie described how her students' experienced nurses who eat their young:

> It usually boils down to them [staff nurses] treating the students poorly, like 'Why did you do that?' or 'I don't have anything for you to do,' or 'I don't want you here, can you go be with another nurse?' We have that all the time.

Unfortunately, these negative behaviors by staff nurses were found to negatively affect the learning environment of nursing students. Nursing students who had excited anticipation of discovering what nursing practice was like lost that zeal after encountering nurses who were unwelcoming and mean. Hope noted how this made her students feel, "Unwanted. Then, they lose that excitement when they first step onto the floor, and they just generally want to stay out of the nurse's way and then they hesitate about walking into those patients' rooms." As reported in the literature review, staff nurse incivility negatively affects student learning (Thomas, 2015).

For decades, the notion of nurses eating their young has shaded the nursing profession in a negative light. This study found these behaviors are still present today and continue to affect both registered nurses and nursing students. Carrie lamented about these behaviors and their effect on the nursing profession:

> It is something about our profession that I really don't like. I really wish that the nurses with experience were more patient with new nurses in training them and teaching them the proper way to do things and the proper way to care for patients so that nursing is seen as a profession.

We are approaching 10 years since Thomas and Burk (2009) published their statement:

> Let us hope that junior nursing students [beginning students] tell the researchers stories of welcoming clinical environments and supportive mentors. Then we can retire the phrase, *eating our young*.

Sadly, the trend has continued.

"Utopia academic nursing" versus "real world" was an element that influenced uncivil actions from both an educational and professional perspective. This finding was not supported by the conceptual model put forth by Clark and her colleagues (2011). Four participants described the disillusionment associated with what students believe the practice of nursing to be versus its reality. Some nursing students were surprised by the reality of nursing practice and the demands it requires. Nursing students could not understand some of the decisions being made by clinical faculty, such as why they could not leave clinical early. This misunderstanding influenced uncivil actions between nursing students and clinical faculty. Trudy's clinical students were complaining because they could not leave clinical early to study. Her statement illustrated the surprise nursing students have when faced with the reality of nursing practice and the demands required as well as how this shaped their perception of her:

> For me it was like I was being mean, because you [nursing students] had to stay the whole time. . . . Sometimes you would see they start *[sic]* getting upset. 'We got to study. We got a test tomorrow and then we have to do this.'. . . I had to address it, I said, 'I understand you got to study. . . . The fact that you have to go home and study after you just spent all this time, these eight hours with me, that's real life. . . . You're going to have to work eight to 12 hours. You *[sic]* going to have to go home, cook dinner, feed those children, do homework.'

Two participants described the influence of how nursing is fantastically portrayed on television shows on nursing students' perceptions of what nursing practice entails. Trudy described it this way:

> Sometimes the students come out with this General Hospital view of nursing. . . . You got that one patient, so you can focus on that one patient. But then you come out and you see us doing six patients. . . . I walk around with my uniform pressed. I said, 'General Hospital don't work in no *[sic]* real hospital. We do not wear stilettos. And yes, our feet hurt at the end of the shift. General Hospital is not a real-life view of nursing.'

To help nursing students understand the reality of what being a nurse entails, Trudy had recommended students shadow a nurse all day, without performing patient care. She noted it helped other students determine they did not want to be a nurse once they saw the reality of nursing practice. A literature review by van Iersel *[sic]*, Latour, de Vos, Kirschner, and Scholte op Reimer (2016) discussed how nursing student perceptions of nursing practice care areas are formed once enrolled into a nursing program, but no literature was found regarding pre-licensure nursing students' perceptions of nursing practice as a profession.

A difference in nursing practice learned in the classroom versus the actual nursing practice that takes place in clinical settings was discussed by participants. Registered nurses compared what is learned through nursing education programs to the reality of applying this knowledge in every day nursing practice. This gap influenced uncivil actions when nursing students were with staff nurses who were performing patient care that did not match what was taught in nursing school. Alaina provided an example of this behavior:

> There is still a perception that there is a utopia academic nursing world, and then there's what the bedside nurses describe as real world. I still hear it almost every clinical where it's something to the effect of 'well I'm

> going to do it this way, but don't tell your nursing instructor, but this is the real world.' I continually see that.

Alaina further described why staff nurses communicate and demonstrate this to nursing students, "There is the perception that academic ideals are not feasible at the bedside. That there are too many demands, too high of acuity patients to adhere to academic ideals that are given in school." A qualitative study of nursing students in the Phillipines found witnessing nursing practice contrary to what was learned theoretically in the classroom created confusion (Tiwake, Caranto, & David, 2015). The confliction of implementing theoretical, impractical practice under the supervision of clinical faculty versus realistic and feasible clinical practice was stressful for the students, who resolved this inner-conflict by deciding to get by with nursing school requirements and then match their nursing practice to that found in their employers' setting (Tiwake et al., 2015).

Clinical faculty also described role conflict between being in the academic setting versus the clinical practice setting. Alaina became tearful as she shared her thoughts about how she feels being primarily nurse faculty instead of a nurse in a hospital setting:

> I never wanted to be perceived as a nurse educator that the students perceived could not function in a hospital acute care setting. I never wanted to be that instructor that didn't know the academic world just as good as the *real world*. . . . I feel like I have to prove myself as a real-world nurse to the nurses at the hospital as well as to my students.

She further described a public encounter with a stranger who saw her identification as a nurse faculty and asked if she missed being a nurse. This led Alaina to believe people in

healthcare, as well as those who are not, have the perception, “You either live in a clinical, practicing world, or you live in academia and the two don’t marry.” This finding was partially congruent with this study’s conceptual framework which identified role stress as a contributing factor to faculty stress, but within the context of “family, school, and work demands” (Clark et al., 2011, p. E43). Additionally, no published studies of identity or role conflict in this context were found, indicating a need for further research into this contributing factor to nurse faculty stress.

Another element of professional influences on uncivil actions was *medical-surgical units versus nursing on other units*. This element collected the meaningful differences shared by registered nurses about the work environments of medical-surgical units compared to other nursing units, such as intensive care units. Five participants compared and contrasted what it is like to work in these environments and how these environments influence uncivil actions.

This study found medical-surgical units to be more stressful and have more hostility between the staff than intensive care units, as presented in Chapter One and delineated in the review of literature. Many factors contributed to the stress of registered nurses on medical-surgical units. Jan spoke passionately about her work environment on a medical-surgical unit, “The whole environment is uncivil. . . . The whole environment's already hostile before you even enter the nurse into the picture. . . . I'm getting anxious just talking about it.” Incivility can go unrecognized due to its

subtle nature and from being ingrained into the organizational culture of hospital settings (Ditmer, 2010).

A lack of teamwork in these types of work environments was reported by many participants. This added stress to busy nurses who did not have the assistance with patient care. Norah illustrated the negative effect of incivility on teamwork and how this decreases the quality of patient care:

> You need to be able to work as a team. . . . I don't need you feeling less than me and I don't need to feel like I'm less than you because that will make me feel like I'm not going to work as a team with you. Then that puts my patient at risk because my patient needs vital signs done and for some reason I have an attitude, then I'm not going to ask my nursing assistant to do vital signs because she's giving me attitude. Or if I need it done then she might not do it because I've given her attitude.

In this study, a problem leading to decreased teamwork within medical-surgical units was staff nurses who would frequently fail to come to work, resulting in understaffing of nursing units. This behavior created a lack of teamwork because staff nurses did not want to help the staff nurse who was frequently absent. Hostile environments of medical-surgical units not only affect patients and staff nurses, but also the learning experiences of nursing students as also noted in Hegenbarth and colleagues' (2015) study. Melanie described how staff nurses responded to her students when she stated, "When you're on these med-surg units, it's very normal, typical, for students to get the cold shoulder from nurses."

Conversely, intensive care units were perceived as having more of a teamwork approach among staff members. Jan had worked on a medical-surgical unit for most of

her career. She had recently become employed on an intensive care unit at a different hospital and made this comparison:

> They have, in the units . . . not in every hospital, but a lot more of a teamwork. Almost an us against them environment in the units. So, as long as that new nurse or nursing student is in that unit . . . she's become one of us or he's become one of us, and they're a little less hostile towards that person.

Unfortunately, one incident of bullying can negatively affect teamwork and communication (Walrafen et al., 2012).

When discussing medical-surgical units, participants also referred to the difficulty of maintaining adequate staff. They mostly attributed the demands placed on staff nurses, such as patient load and physical nature of the job, for this difficulty. Charlotte's statement highlighted different reasons for the difficulty of staffing medical-surgical units, "General med surg floors are hard to staff. . . . Nobody wants to be a med surg nurse. . . . Because there's no glory in it. It's very physically demanding. It's very demanding in your patient load." As indicated in the conceptual model by Clark and her colleagues (2011), a lack of human resources and increased workloads contribute to increased stress and poor working relationships between nursing education and nursing practice and has been heavily discussed in the literature (Martel, 2015; Thomas et al., 2015).

Critical care areas were described as "glory jobs" that staff nurses may find more attractive because there is less walking and fewer physical demands. Additionally, patients in these areas frequently require resuscitation to sustain life, therefore, staff

nurses may find these areas more exciting. Charlotte explained what was meant by “glory jobs” when she stated that "you don't 'rescue someone from death,' like you do in an ICU or an ED, so those are the glory jobs." Nurses in critical care areas are frequently perceived as more valuable than nurses who work in medical-surgical areas (Ditmer, 2010).

Subtheme: Physical and psychological influences. This subtheme encompassed the sources of stress registered nurses encountered during the course of patient care. Registered nurses described feeling “a lot of pressure” from their organizations throughout their shift. The tolls that led to physical and mental fatigue, such as patient acuity, workload, and being required to do everything except “just nursing” were also described. The congruency of most of the findings within this subtheme with aspects of the conceptual model for fostering civility in nursing education, as adapted for nursing practice, will be explicated (Clark et al., 2011).

Eight participants were forthcoming about the organizational and environmental influences that create a lot of pressure in clinical settings, leading to the potential for uncivil actions. When working as staff nurses most pressure was felt from understaffed nursing units and high patient acuity, which created difficult workloads during their shifts. These pressures were outlined in the conceptual model of Clark and her colleagues (2011) and were described as contributing factors to both stress for practicing nurses and poor working relationships between nursing practice and nursing education. These pressures were also noted by other authors as having a negative

effect on clinical learning environments (Hegenbarth et al., 2015). Myra said, "Nurses work under so much stress. . . . The acuity of our patients is absurd. And then your nurse patient ratio . . . you can't provide good quality nursing care to these patients." Elizabeth, a staff nurse on an intensive care unit, talked about these pressures in relation to having nursing students in her work environment:

> Patients are much, much sicker. Nurses have more responsibility with things that take longer, like charting. I think when you add in all these stress factors, and then you have a student . . . and working long hours, sometimes it just feels like I can't deal with one more thing, and that's just one more thing.

Carrie described how patient acuity is a factor that can contribute to incivility in the clinical education setting and affect the relationship of registered nurses who are preceptors for nursing students, "Putting a student with a nurse . . . that's working overtime, that's maybe stressed . . . the patient acuity . . . it can all just depend on the nurse and the student's relationship." These findings fill a gap found in the literature about why incivility continues to plague acute care settings. Clark and her colleagues (2011) reported stress as a major contributing factor to incivility for over 10 years. Until stakeholders within the nursing profession address overwhelming workloads with high patient acuity, incivility and other disruptive behaviors stand no chance of being resolved. Jan was "getting anxious just talking about" working under the pressure created by the organizational climate of her former employer. These findings support

Clark and her colleagues' (2011) claim that added workload and patient acuity causes staff nurses to experience stress and if opportunities are not taken to intervene, incivility in the learning environment can occur.

Nurses perceived a lot of pressure to accomplish nursing tasks in a certain amount of time as determined by their healthcare organizations. The pressure created by time constraints affected the clinical education setting. Norah's uncivil encounter with a nursing student stemmed from being "busy" on her nursing unit, which meant medications had to be administered by certain times, electronic charts had to be open by a certain time coupled with doctors rounding on patients and nursing care to be performed on assigned patients.

Busy nurses found it difficult to include teaching in their work routine. As noted by Hegenbarth and colleagues (2015), staff nurses can become angry or aggravated by the additional responsibility of having to educate nursing students in addition to their assigned patients. Three participants in my study talked about having no time to teach. Jan found herself being "impatient" and "snippy" with nursing students who were asking her "a million questions." She attributed this reaction to having "way too much on my plate, and I really do not have time to teach." Melanie said nurses, "Don't have time to teach" because of the demands and expectations of the healthcare institution. Elizabeth pointed out nurses "are overworked, they work long hours, understaffed. Patients are sicker now . . . and to have somebody that's new and doesn't really know

what they're doing, people just . . . don't have time to teach." Elizabeth expressed concern about the safety of her critical care patients when nursing students were present:

> I don't mind teaching, but I do feel like I need to be a little bit less busy. I don't need two of the sickest patients so that I can watch what they are doing because they're learning. They could make a mistake very easily not meaning to.

Thomas and her colleagues (2015) found nursing students who experienced incivility from staff nurses did not believe *being busy* justified their disrespectful actions.

Staff nurses' workloads felt overwhelming when coupled with high-acuity patients. It was also revealed that nurses were frustrated by additional responsibilities placed on them by healthcare organizations. Providing basic nursing care without being overwhelmed by these other responsibilities was important to staff nurses' well-being and fulfillment as a registered nurse. Jan felt like she could handle caring for up to five patients if she was "just nursing." This response from Jan revealed an underlying source of frustration most registered nurses alluded to throughout the study. She continued, "What all are you asking your staff nurses to do. Are they being just nurses, or are you asking them to do a lot more besides nursing? Are you asking them to be dietary, housekeeping, pharmacy?" Jan described what "just nursing" means:

> You're hands on patients. You are medications, assessing, reassessing, calling physicians. You're being the center of everything that patient needs. . . . You're not running all over the hospital to get IV pumps. You're not calling dietary, "You got the food wrong again." You're not running and reheating up food. You're not running down to pharmacy because they haven't stocked something. You're not running to central

> supply. You're not calling the supervisor because you've had seven admits on a 20-bed floor and you don't have the nursing staff to absorb it. And probably the charge nurse should not be having a bunch of patients.
> They should be more of a resource instead of trying to take care of patients, and also running and getting everything as well. Bedside nursing is bedside nursing. That's what nursing is to me.

Patient care was described as being the heart of nursing. Nurses were described as being called to care for people and meet their needs. Jan described how nurses are frustrated when they can't "even get to the basic of what nursing is" and when "they're overworked, busy, and just don't feel like they have enough time to get done what they need to get done."

Workload of both faculty and registered nurses encompassed physical and psychological influence on uncivil actions and was also a major contributor to poor relationships between faculty and practicing nurses in the conceptual model of Clark and colleagues (2011). Five participants discussed clinical faculty workload. All but one participant described how clinical faculty having up to 10 students made the faculty unavailable to most students, which caused students to wait and patient care to be delayed. Joe illustrated how clinical faculty can experience stress:

> No matter what kind of best-laid plans are out there, there's always a modification of those plans because something took a little longer than you had anticipated, or something came up that you had not anticipated. Patients will have other needs when you go in to do one thing, three other things will come up. So, you find, as a faculty member, that you're frequently running behind. And there's always a student sort of waiting in line, and I marvel many times that the students are patient and civil in waiting their turn, because they know the time frame and they are . . .

> hurrying up and waiting. And so, all of those . . . are factors that can lead to stress that may make incivility more prominent or make that surface.

Melanie summarized, "There's no way the clinical instructor can meet all of those expectations and wear all these hats and fulfill all these roles. So, then it falls on the staff nurse, and they're already overworked." In several studies, nursing students asking questions of nurses either were refused answers or referred back to their clinical faculty (Anthony & Yastik, 2011; Thomas & Burk, 2009).

Stress stemming from difficult workloads not only influenced uncivil actions, but also led to turnover. The negative effect incivility has on the nursing profession can be found with students deciding to stop their nursing education or reconsider nursing as a career (Anthony & Yastik, 2011; Martel, 2015). Jan referred to the "huge turnover" from the "overworking and hostility" as she recounted her work environment on a medical-surgical unit. She said with a tone of relief, "Glad I don't work there anymore." Nurses' experiences of disruptive behaviors lead them to consider leaving their jobs or the profession (Hutcheson & Lux, 2011).

The conditions on Myra's medical-surgical unit created "complete turnover all the time." Nurse managers were not excluded. Charlotte had conducted clinical education on a medical-surgical unit for 10 years. She literally counted seven managers this unit had over this time period and referred to the "high turnover" of the unit. Charlotte found it remarkable there were "always new people" each semester, referring to how nurses just "don't stay long." Walrafen and colleagues' (2012) study found nurse

retention is negatively affected when horizontal violence is allowed to permeate work environments without intervention.

"And then you have a student" was an element of the psychological influence of uncivil actions within hospital settings. This element addressed a gap found in the literature review by describing what staff nurses perceive to be contributing factors to stress and incivility during the clinical education of nursing students. In my study, stress from high acuity patients and increased workloads contributed to hostile work environments. Staff nurses described nursing students as an additional stressor to their work environments.

Although staff nurses in this study indicated they did not mind teaching nursing students, Amann & Williams (1960) found in their study nurses have ambivalence about the presence of nursing students in clinical education and feel they take too much of their time. However, staff nurses overwhelmed by heavy workloads saw the addition of a nursing student as an additional stressor. Elizabeth verbalized how she felt having a nursing student in the midst of a busy shift:

> Nurses have more responsibility . . . things take longer like charting. I think that when you add in all this *[sic]* stress factors, and then you have a student, sometimes and working long hours, sometimes it just feels like I can't deal with one more thing, and that's [having a student] just one more thing.

Nurses on the nursing unit where Rose conducted clinical education were overwhelmed by their workloads. Rose reiterated nurses' responses when they found out they were

going to have nursing students with them. She also explained how this influenced uncivil actions:

> The nurses are overwhelmed, overworked and underpaid. They want to find anything they can to not to have to deal with students that day. . . . The nurses are like, 'Oh, I've got so many patients. I'm not going to be able to take a lunch break today,' . . . It makes them irritable. You're more irritable, you snap . . . at everybody.

Elizabeth lamented, "I think most nurses, and it's just true, when they hear they're going to have students, they roll their eyes because they think it's going to be extra work, or extra teaching someone." These descriptions are supported by the conceptual model by Clark and her colleagues (2011) that noted how the workload of nursing staff in high-stressed environments leads to adverse working relationships.

Staff nurses found nursing students to be distracting because of the barrage of questions they posed to nurses during busy shifts. They were also frustrated by nursing students who asked questions at inappropriate times, such as during medication preparation. Jan voiced her frustration:

> They're [nursing students] asking you questions and going, 'Why are you doing this?' You get snippy. . . . It's not an intentional thing. It is not I'm trying to be mean. It's like, I've got to do this for this patient or I could harm this patient, so while you're distracting my brain while it's on these million other things, you might go, 'It's Cardizem!' [in a short, exasperated tone]

This barrage of questions from nursing students combined with being overwhelmed by patient workload had a synergistic effect on nurse fatigue. This finding was not supported by the literature review or this study's conceptual framework. Carrie

explained how the frequent presence of nursing students can lead to nurse fatigue, "We [staff nurses] can, in general, be tired of precepting all the time, be tired of teaching over, and over, and over again when we are a nurse and not a teacher." Jan exemplified how the presence of nursing students can lead to uncivil actions when she said, "I've found myself being impatient after they've [nursing students] asked me a million questions, and I might've snipped an answer back to them." Unlike the findings in studies by Martel (2015) and Thomas and her colleagues (2015), nurses in my study reported responding to students' questions but in an uncivil manner.

Theme Two: Experiencing and Responding to Incivility

The theme *experiencing and responding to incivility* captured registered nurses' descriptions and definitions of incivility. Participants also described differing responses to these encounters. The subthemes supporting this overall theme includes *describing incivility, witnessing incivility, "spoke truth," and "pray for us."*

Subtheme: Describing incivility. The experiences of incivility shared by participants were analyzed for the way incivility was described. Additionally, participants were explicitly asked to define the term incivility. These registered nurses described different types of uncivil behaviors, including verbal and physical behaviors and attitudes (see Table 3). These behaviors were exhibited in both nursing students and registered nurses, including staff nurses and clinical faculty, and were targeted either directly or indirectly toward other individuals.

Overall, incivility was prominently perceived as negative attitudes with verbal and physical characteristics. Incivility was primarily described as disrespectful and was deemed unprofessional behavior. Attitudes were mentioned more than 65 times throughout the transcripts of the interviews and were described mostly as "disrespectful," "angry," "frustrated," and not accepting responsibility. Uncivil behaviors were mostly described as mean, hostile, uncaring, uncooperative, and most commonly resulted from stress. A noticeable pattern was discovered within each of the uncivil encounters described by participants: Each consisted of two or more types of uncivil behaviors. Carrie's description of the attitudes and behaviors she encountered from her clinical students encompassed verbal and physical types of uncivil behaviors, "They would roll their eyes, they would cross their arms, lean back on their chairs. Some of them would even while you would be talking, just let out a sarcastic giggle or laugh. Or be on their cellphones." Jan's description of a staff nurse's reaction to a nursing student's assessment of a patient contained a demeaning attitude combined with anger and uncivil verbal behaviors, "The nurse was very frustrated with the student, said, 'I'm not calling the doctor over that. I don't think that's what's going on. That's ridiculous.'. . . She was very irritated and angry at the student."

More verbal behaviors were described than physical behaviors. The most prominent of verbal behaviors was the tone of voice used by individuals. This included short responses, harsh tones, and being direct. Being argumentative and accusatory were also forms of uncivil verbal behaviors. The most prominent physical behavior

reported by participants was body language, described mostly as eye rolls and facial expressions, followed by repeated, indiscriminate cell phone use.

Table 3

Participants' Descriptions of Types of Uncivil Behaviors

Verbal	Physical	Attitudes
Harsh tone of voice	Eye rolling	Uncaring
Argumentative	Facial expressions	Demeaning
Accusatory	Finger pointing/waving	Retaliatory
Being direct	Unengaged with learning	Aggressive
Foul language	Being unprepared for clinical	Hostile
Name calling	Unprofessional appearance	Angry
	Inappropriate use of personal technology	Selfish
		Entitled
		Flippant
		Rude
		Defensive
		"Greater than thou"

Common terms used in the literature to describe disruptive behaviors were incivility, bullying, vertical violence, verbal abuse, and workplace violence. This fragmentation of terms led to individuals not realizing they were experiencing incivility. Therefore, this fragmentation has contributed to confusion of how to communicate the type of interaction one has experienced, potentially inhibiting one's ability to seek appropriate strategies for these disruptive behaviors. For these reasons, participants were asked to provide terms they associated with incivility. They provided the following

terms: a) disrespectful, b) hostile, c) impatient, d) irrelevant, e) impatient, f) negative attitude, g) rude, h) uncaring, i) uncooperative, j) unprofessional, and k) violence.

Only four participants used terms commonly found in the nursing literature regarding disruptive behaviors. Participant #7, Myra, was the first to use the term *violence*. She clarified what she meant by this term and then described other thoughts that came to mind when she thought about terms associated with incivility:

> It doesn't always mean violence. But incivility, unprofessional behavior, I think of mean. I think of disrespect. I think not pulling your weight can also be considered uncivil in the way that we treat each other in this profession, of 'that's not my job.' Ultimately the patient is the one that is suffering here. I think of that as uncivil behavior.

Alaina stated the words, "Hostile, workplace violence, and bullying." Hope said, "Hostility, attack. Like you're warring with each other on opposite sides." Joe had several terms that came to mind. His statement was similar to Myra's:

> It's behaviors that can be perceived as rude, off-putting, bullying, hazing . . . I think another term that's often used now in the clinical environment is lateral violence against another. So not violence in the respect of physical violence, but those things of bullying and hazing and so forth, can really be detrimental to the student or to the nurse or to the individual psyche, so far as the professional educational process. And it can ultimately result in patient safety issues.

Other terms common among participants were unprofessional and disrespectful. Carrie said she thinks of "disrespectful, uncaring, and unprofessional." Charlotte thought of "unprofessional, uncaring, unconcerned, mean." Melanie stated, "Unprofessional, gossip, stirring the pot. . . . The big thing is being unprofessional. Causing issues among people."

Attitudes of negativity and impatience also came to participants' minds when thinking of terms associated with incivility. Jan described several terms:

> Impatient. Frustration. Probably insecurity about their own job roles. . . . If they [nurses] feel like they don't know or can do something or didn't know something more than a student, then I think they feel threatened by that somewhat. Maybe threatened. Impatience. There's a lot of emotions that probably go into that, and it's probably not just one thing. Then, there's the female-to-female thing.

As mentioned in theme one, *nurses eat their young,* was used to describe the negative attitudes of experienced nurses who were impatient with less experienced nurses or nursing students. Elizabeth also referred to the impatience of nurses:

> Negative attitude again. Actually, if I could use the phrase, 'nurses eat their young.' I've heard that my entire career, and it's true. Nurses have the notorious reputation for not having the patience to put up with teaching somebody that doesn't have the experience that they do.

Defining incivility was surprisingly difficult for participants. A possible explanation is the fragmentation of disruptive behaviors into different behavioral categories such as horizontal and vertical violence, bullying, mobbing, and the like. There were some participants who had to validate the meaning of incivility when responding to the study invitation. Others had difficulty defining incivility, as Joe noted, "It can take on many facets." Melanie stated outright, "That's hard to answer because I feel like it's at so many levels." Not surprising were the inclusion of the common terms associated with incivility as previously discussed: unprofessional and disrespectful. Alaina defined incivility as a "lack of respect for your fellow human that stands before you." Charlotte stated, "Incivility means . . . being unprofessional, inappropriate,

misbehaving." Elizabeth drew on the incivility she witnessed between a staff nurse and a nursing student, "Being hateful, non-cooperative in trying to teach someone. . . . Just a general attitude of negativity." Luparell (2011) described incivility as "rudeness, disrespect, and general disdain for colleagues" (p. 92).

Despite finding difficulty with defining incivility, Melanie provided a description of circumstances in which incivility was present:

> Anywhere from uncivil behavior being chewing gum or pulling your cellphone out to clinical to kind of the extreme incivility, which is what I . . . saw at preceptorship and how he's been uncivil throughout his career. So, causing a lot of issues among colleagues. Stirring up drama. Not working as a team. Healthcare, everything is about team work. If you can't work as a team, you're not going to be able to provide good patient care. . . . It's kind of hard to give a specific definition because there's so many different layers of incivility.

Joe's words illustrated how the various terms for disruptive behaviors are often used interchangeably, "Being less than courteous and civil to another individual, and I know that that can take on many facets, I think, in the clinical arena. A lot of times, it's identified as lateral violence against another individual." Myra's definition provided a good summary of what incivility means:

> When we're not treating each other the way we want to be treated. I mean it's just a break in the Golden Rule. I think there's lots of different ways that you are uncivil, that we can be uncivil. But it boils down to when we're just not treating people with kindness and in the way that we would want to be treated and with respect.

Surprise was the most common initial reaction of targets of incivility, as also noted in previous studies (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; &

Walrafen et al., 2015.) Unexpected uncivil actions “shocked” and “startled” both clinical faculty and nursing students. Jennifer, a clinical faculty member, encountered incivility from a nursing student who was unhappy with her patient assignment, noted, "It just startled me 'cause *[sic]* I didn't expect it." Nursing students were frequently shocked to witness incivility from their classmates. Jennifer described how students reacted to another student’s incivility, "Some of them was as shocked as I was, and some of them were her friends." Students in Myra’s clinical group witnessed her chasing an uncivil student who ran from the break room where she had addressed his unprofessional behaviors, “They were just in shock. . . . All of their mouths were open. . . . They were just standing there. 'What do we do? What's going on?'" Luparell’s (2004) study of incivility found every faculty member was surprised by the uncivil behavior they encountered from nursing students. Similarly, subjects in a study referenced by Schön (1983) responded to errors in their actions with surprise which was termed an “action-response.”

Concern for the target was a secondary response of individuals who witnessed the targets’ direct incivility. This was noticeable in Elizabeth’s witnessed account of incivility from a staff nurse to a nursing student, “I really just felt sorry for the student.” Nursing students witnessed direct incivility toward Myra from a fellow nursing student and were described as “shocked.” Myra described their secondary reaction following the uncivil event: “They were very sweet afterward. I remember one giving me a hug and saying, you know, ‘Ms. Argile, don't let this get you down.’

"Had an attitude" was an element of the subtheme *describing incivility* that encompassed the numerous reports of negative attitudes registered nurses described as incivility. Participants revealed both registered nurses and nursing students "*had an attitude"* when referring to uncivil individuals being disrespectful, unprofessional, and defensive. Seven accounts of nursing students' displaying negative attitudes toward clinical faculty and staff nurses were described. Negative attitudes associated with uncivil nursing students by registered nurses included not being able to accept being wrong, being uncaring with a lack of compassion, and a lack of respect. Melanie's description of a nursing student gave meaning to having a negative attitude:

> He would be a nightmare to have as a new grad when he graduates, because . . . he had this attitude of 'I know everything, I'm better than everyone else.' . . . He has a reputation for not following the rules.

These behaviors are concerning as students who have difficulty controlling disruptive behaviors with faculty may be also be unable to control them during interactions with patients and coworkers (Luparell, 2004).

Defensive attitudes were revealed from participants' descriptions of their uncivil encounters with nursing students. These types of attitudes were most prevalent when students were found to be in error and unable to accept they were wrong, but some nursing students were described as having a persistently defensive attitude. Carrie illustrated the defensive attitudes nursing students would display in regard to medication preparation:

> Some of the students we had were, I would say less than safe with their drug calculations. . . . Sometimes there would be confrontation between the nurse and the nursing student because the nursing student was unable to calculate successfully the correct amount of medication to give, and when they're asked to recalculate they become defensive of their answer.

A student displayed a defensive, argumentative attitude toward Alaina in front of a patient for whom she was trying to start an intravenous line:

> The student said, 'It's right there. Can't you see it?' [spoken with smart aleck tone] 'I don't see anything in the flash chamber, so we need to stop and withdraw the needle.' [spoken with soft tone] 'But it's right there. I do this all the time.' [spoken with loud, harsh tone] 'There is no blood in the chamber. We need to remove the needle and hold pressure." [spoken with soft tone]

Melanie was a clinical faculty member who taught in the second year of a BSN program. She described a nursing student with a sense of entitlement who would not comply with clinical requirements which led to him being counseled on campus by her and an administrator of the school:

> It was just like that repeated 'I'm not going to follow the rules, I don't really care that you have rules, this is about me,' and just being very arrogant. Not doing his paperwork and just sitting. . . . He just never seemed to take initiative to get things done. . . . He just seemed to have kind of a chip on his shoulder. . . . Evidently, he had it throughout the program.

These findings are consistent with Luparell's (2011) report explaining why incivility persists. Oftentimes, uncivil students are intelligent enough to progress through nursing programs, becoming employed on nursing units where their uncivil behaviors continue. Melanie's statement evidences this reality:

> There's this one guy . . . he precepted in the unit that I worked on at the local hospital. This was years ago. He was very uncivil. . . . I know that uncivil behavior has carried out throughout his professional career, and he's had to move to a couple of different areas because he's caused a lot of problems.

Being disrespectful was found to be an underlying thread of incivility, described as unprofessional behaviors that were argumentative, accusatory, or undermining in nature. Charlotte defined what being disrespectful meant to her when she stated, "Arguing in a non-constructive manner. . . . When I feel like I'm being attacked. . . . When I'm accused of something." In Melanie's description she summarized the effect of these uncivil behaviors from nursing students as "disrespectful to you, to the program, and to the profession."

Unprofessional behaviors included physical appearance, being unprepared, unengaged with learning, and a focus directed away from patient care. Sadly, some of these behaviors occurred at the bedside of patients. Carrie referred to a nursing student who was assigned to her to earn preceptorship hours. Instead of focusing on the patients, Carrie described her behavior:

> Talking with some of the other nurses when I was doing the actual patient care, just very uninvolved, not looking at the orders. . . . Just very unconcerned with the situation like she was just there to gain hours and not experience.

Rose described the unprofessional appearance of a nursing student with "dirty fingernails, unkempt clothes, smelled like smoke."

The inappropriate use of personal technology was considered to be incivility by three participants. Besides being inappropriate within patient care areas, nurses also considered nursing students' inappropriate cell phone use as a way to not follow clinical faculty instructions and to demonstrate inattention toward clinical faculty. Melanie described how a nursing student's behavior regarding a cell phone influenced incivility:

> He wanted to push the limits, so I caught him out with his cellphone out three different times, and on the third time, I wrote him up. . . . They're told in orientation that . . . you can't pull your cellphone out in clinical.

Using cellular telephones for personal communication at nursing stations was found to affect patient care. Carrie described a nursing student as "uncooperative, on a cellphone texting, and not really paying attention to what was going on with the patient's needs" after the student had already been instructed to not have a cellular device in the patient care area.

"It's just sad" was a repeated description used by participants when *describing incivility.* This description was used to describe the presence of incivility in the nursing profession and the accompanying lack of altruism and respect for others. Myra talked about incivility in the nursing profession:

> Just this attitude of, that loss of altruism in this profession, it makes me sad. And so, I feel like in a lot of ways, this incivility is bred right from within and it's encouraged, and it's this attitude we should be proud of it instead of . . . approaching it with empathy and having respect for our fellow man, it seems to be lost in a lot of ways.

In Martel's (2015) study of incivility, nursing students were surprised by the lack of caring within the caring profession of nursing. Charlotte also alluded to this irony when

she discussed the prevalence of incivility throughout the profession of nursing and why it persists:

> It's just sad how we treat each other. And we see incivility not only with students, but we see it with professionals who are supposed to be professionals, and I think it's just a sad commentary on nursing. Unfortunately, you're seeing it in everywhere, but nursing, especially to me is supposed to be an altruistic, caring, giving profession and I think when we treat each other uncivilly . . . it's sad.

Clinical faculty expressed sadness in regard to uncivil nursing students who graduate to become uncivil registered nurses, confirming what Lashley and DeMeneses noted in 2001 that students' disregard for professional behaviors could result in them becoming unprofessional nurses. Melanie stated, "When I have uncivil students, it makes me sad because I know some of these behaviors will carry on to their future careers. Their uncivil behaviors could translate to poor patient care. That's difficult." Myra referred to a student who had physically assaulted her during clinical, "I've spoken to nurses that have worked with him and the care that he provides . . . it's just sad to know that that type of nurse is out there."

Tit for tat was an element describing the back and forth nature of incivility. Participants spoke about responding to incivility with incivility. Clark (2008b) described this behavior as a dance where one uncivil action toward another may be reciprocated with incivility. Norah blamed uncivil nursing students for staff nurses not wanting to help overwhelmed clinical faculty, revealing an effect of incivility on clinical education:

> If there's incivility, then, there's stress and nobody wants to help anybody; so, the instructor's overwhelmed because they're *[sic]* having to

> do everything for all these students . . . because the staff is not going to lift a hand to help. You know, show stuff or do stuff, or whatever that you could easily help with.

As presented earlier, Melanie exemplified one aspect of Clark and her colleagues' (2011) conceptual model when she did not respond with incivility to an uncivil action, thereby creating a culture of civility. Norah on the other hand demonstrated the other aspect of this conceptual model of moving toward a culture of incivility by choosing to respond to incivility with incivility, as exemplified by her reasoning of not helping frustrated nursing students and clinical faculty:

> Most of the time when folks feel like somebody's being uncivil toward them, they don't want to be in their presence. . . . They have that same attitude toward, 'Okay, you're going to be that way toward me, I'm going to be that way toward you.'

Being focused was an element of *describing incivility* that captured how registered nurses perceived incivility when either nursing students or staff nurses were focused on tasks. An example was provided by Norah which also illustrated how incivility can be unintentional:

> I just think that they're focused. . . . I can remember when I was a nursing student and in clinicals, you're just focused. You're focused on you have this task that you need to do and it's your experience, it's your clinic thing and you really don't think about other people. You know? That are there. It's just you and your clinical experience. . . . You just don't think about anybody else there. You know? I don't think it's just, 'Oh my god, I just want to be uncivil to these people.' But I think it's just they're focused.

Staff nurses focused on patient care were confronted about being uncivil. They were unaware of their directness and tone of voice when intently assisting with patient care.

Jan's response provides an example of how staff nurses' focus on patient care can be perceived as incivility:

> It's all about I guess who perceives it. It's not necessarily about how you mean it in this environment. . . . There's stuff going on. These people are gonna die. I don't care if you're feeling anxious and you need me to throw that at you. Okay, here. Where some other people are like, 'Gosh, you yelled at me to give you Atropine.' The patient was *dying*! . . . . I've heard them discuss, 'In code situations, there's no reason to be rude.' I'm like, are you kidding me? You want me to ask you how your mama is before you hand me that Atropine?

Being focused prevented clinical faculty from recognizing incivility from students. Hope was teaching during post conference with another faculty present. She described being in front of students who were treating her disrespectfully while the other faculty member did nothing to prevent it:

> You're so focused on the instructions or the lesson that you're delivering to them [students] that you're not picking up on their nonverbal and watching them. . . . She [the other faculty] wasn't picking up or recognizing and seeing things what I was seeing. Because when I would discuss it with her, she would act surprised at times.

Faculty can face a range of disruptive student behaviors, from mild to severe, including disrespectful, sarcastic remarks, and being indignant toward faculty (Luparell, 2004).

Subtheme: Witnessing incivility. This subtheme was derived from nine participants' descriptions of witnessing uncivil encounters and how their experiences affected them. Most of the witnessed accounts of incivility involved patient care. Disturbingly, the findings revealed the negative effect of witnessing incivility on the

growth of the nursing profession. Experiencing incivility from any source can result in emotional exhaustion, a component of burnout (Babenko-Mould & Laschinger, 2014).

Uncivil behaviors can be learned by nursing students who witness these disruptive behaviors from the registered nurses who are working in their clinical education environments. Luparell (2011) suggested repeated exposure to these behaviors could create a normalcy of uncivil behaviors. Nursing students in Randle's (2001) study were "shocked and surprised" (p. 295) by the unprofessional behaviors of staff nurses, but by the end of the program students found this behavior acceptable. Nurses can transfer their value system to nursing students which can affect students' manner of patient care (Thomas et al., 2015). Rose offered how she managed her students within uncivil clinical education environments:

> You can pick up some bad habits from the nurses. I even tell them [students], you've got to learn stuff from everybody, even if it's not what to do right? If you're with a crappy nurse that day, and I try not to put them with crappy nurses but occasionally that's all we got. I tell them, okay, this one right here, she's crabby as an apple. Learn how not to be.

The students in Randle's (2001) study went along with the nurses' behavior, vowing to change their behavior after their training. Walrafen and her colleagues (2012) explained nursing students tend to adopt the behaviors of the individuals of a group to which they wish to belong. Additionally, being treated with incivility during clinical education has led to nursing students questioning nursing as a career choice (Martel, 2015).

Witnessing nursing students as targets of incivility caused most nurses in my study to become protective of students, in part from knowing the consequences of

incivility. This finding is supported by Schön's (1983) reflection-in-action theory which explains how past experiences with a phenomenon creates tacit knowledge about the phenomenon that a person can draw from when faced with a similar situation in the present or future. Nurses felt the need to protect students' self-esteem and the nursing profession itself. Jan illustrated the importance of protecting inexperienced nurses and students:

> I am very protective over new nurses and nursing students because I feel like they're almost like your children coming up in the world. You need to ensure that they can learn, they have a good learning environment, because it will make them better nurses. And you don't wanna *[sic]* bully them out of the field. We're working with way too few nurses.

Trudy described how she protected a nursing student by rescuing her from an uncivil encounter with a staff nurse, "She stayed with me. I said, 'Just go feed my patient. She take *[sic]* one bite every five minutes, but just stay with my patient and I'll finish [the task].'"

Witnessing incivility within clinical education settings can affect healthcare facilities' ability to hire qualified nurses. This may be attributed to a common characteristic revealed from the data analysis: Where incivility is present, people would rather be absent. Incivility negatively affects the nursing profession when students stop their education or reconsider nursing as a profession (Anthony & Yastik, 2011; Martel, 2015). Jan described a nursing student she was precepting who witnessed an uncivil encounter between Jan and a hospital administrator:

> They're gonna witness hostile behaviors back and forth. . . . The last student I had . . . I went down to talk to the supervisor about an issue . . . the supervisor was very snippy at me about it, and she [the student] just said, 'I'm never gone *[sic]* work here.'

Clinical faculty witnessed incivility mostly staff nurse incivility toward nursing students rather than to other staff nurses. Charlotte noted, "I don't say we witnessed incivility among the staff as much as we witnessed incivility as staff to student."

Study findings suggest incivility among staff nurses continues to occur due to the hostility of their work environments, despite published findings of the danger of these behaviors and policies created to address this issue, as discussed in Chapter One (Academy of Medical-Surgical Nurses [AMSN], n.d.; Hunt & Marini, 2012; Lucian Leape Institute, 2013; National Council of State Boards of Nursing [NCSBN], 2011). As already discussed in this current study and as supported by the conceptual model created by Clark and her colleagues (2011), allowing stressed individuals to continue working in stressful environments will ultimately lead to incivility unless actions are taken to create a culture of civility. Incivility among staff nurses occurred in the presence of nursing students and was sometimes directed toward nursing students, as previously discussed. Jan referred to the presence of nursing students when she noted, "They'd have to have ice in their veins not to feel that or know that or see that, even if it wasn't directed toward them." When asked if she thought this could change a student's perception of nursing she responded, "Yes, definitely. I don't know how it couldn't. It did mine."

Subtheme: “Spoke truth.” The subtheme *“spoke truth”* included the effectiveness of policies and procedures on registered nurses’ incivility and how authority figures initially responded to incivility by discussing existing policies. Most hospitals and academic institutions used policies and procedures to outline expected behaviors. Unfortunately, the majority of participants were unaware of hospital policies regarding incivility. Clinical faculty were more familiar with schools’ policies and procedures than with hospitals’ policies. However, most could only refer to where the policies were located, such as the faculty handbook. They could not verbalize the specific consequences for uncivil behavior. These differences will be explained as well as the areas of improvement identified during the analysis.

Due to their professional responsibility of evaluating nursing students in clinical education, clinical faculty “*spoke truth”* to nursing students, using facts from policies to remind students of appropriate professional behaviors. This action was supported by Schön’s (1983) reflection-in-action theory that explained how individuals can draw from guidelines to solve problems when no experience with the phenomenon has yet been gained. In other words, students draw from knowledge of appropriate behaviors to act appropriately in clinical environments. Faculty members described pulling nursing students aside to privately discuss issues about their clinical performance and returning them to patient care, never having to address the issue again. Melanie explained how she *“spoke truth”* to nursing students when she stated, "Most students I can pull aside in clinical because it was very minor, something they didn't realize they were doing, and

I always saw a big difference in their behaviors." Rose described how she addressed unprofessional behaviors of a nursing student in a clinical education environment:

> I would always tell him what the truth was. . . . That's textbook or is policy and procedure, I'm going to convey that to you. . . . I just spoke truth to him. Told him this is what the protocol is.

It is the responsibility of nurse educators to ensure nursing students are committed to professional standards prior to entering nursing practice (ANA, 2015a). In my study, holding nursing students accountable for unprofessional behaviors resulted in all clinical faculty becoming targets of incivility by nursing students. Likewise, Luparell (2004) found students unexpectedly acted aggressively toward nurse faculty after students' clinical performance was criticized or they failed a course. Uncivil nursing student behaviors experienced by clinical faculty included constant eye rolling, disrespectful tone of voice with inappropriate language, body language to express disinterest in what the faculty was saying, being argumentative and accusatory, snide remarks, rudeness, and uncaring attitudes. Myra described the most violent account of participants' encounters of incivility with nursing students, which occurred after holding the student accountable for unacceptable clinical behavior. She described how she pulled aside a nursing student who had arrived at least 20 minutes late to clinical to inquire why he was late. Later, after he had begun patient care, he came out of the room with dirty gloves on so she asked him to meet him in the break room. As she began to talk to him about infection control he became angry so she told him he was dismissed from the clinical day. She described his response:

> He just, in a huff, grabbed all of his stuff and walked to the door. . . . He had a Mountain Dew bottle in his hand, and he turned and he threw it at me, and it hit me in my clavicle. And he said, "Go to hell, bitch." And took off running. I was 26 weeks pregnant at the time. . . . I was drenched in Mountain Dew.

Participants' descriptions of incivility demonstrated a similar escalation in behavior that ultimately resulted in incivility. These findings were consistent with the literature review which found faculty experience verbal abuse as well as physical assault, with a significant association between verbal abuse from nursing students toward faculty who taught within public institutions (Lashley & DeMeneses, 2001; Luparell, 2004).

Accountability for nursing students' clinical behavior is routinely documented on clinical evaluation forms. Ultimately, clinical failure can occur if disruptive behaviors continue. Alaina provided a detailed description of how this form is used to evaluate clinical performance:

> Within evaluations, there are many objectives that address professional behaviors. We spend a lot of time in what that means to have professional behavior in how we look and how we dress and how our inflection and tone is in our voice, how we communicate. So, there are means to give guidelines to what expected behaviors are, and if those expected behaviors are not met, then it meets with unsuccessful performance.

This study revealed students usually responded to verbal feedback without incivility, but those who had a history of incivility responded with incivility. Clinical faculty's' descriptions of encounters with uncivil students revealed uncivil behavior was repetitive unless significant consequences resulted. Melanie described a nursing student who did not respond to being pulled aside for guidance from clinical faculty:

> I brought him in, and we had kind of like a remediation with the head of the clinical course and myself and talked about his unprofessional behaviors. He . . . was a little disrespectful in that meeting and had an attitude and rolled his eyes a couple of times. . . . We just spelled out what our expectations were and why he was brought in. He said, 'Well it doesn't matter what I'm going to say, I'm not going to win anyway,' so he just got up and left.

After being held accountable for their incivility, this study found nursing students responded by doing the minimum requirements in order to successfully complete the semester. Although this finding was not supported by the conceptual framework, Luparell (2011) discussed how intelligent nursing students are enabled to successfully complete nursing programs if their uncivil behaviors are not a factor. Melanie described such a case, "He did come back and finished the clinical rotation. He didn't talk much. He just did what he had to do, the basic paperwork and finished. It wasn't like I couldn't pass him, but he was just very unprofessional."

Interestingly, nursing students who were targets of incivility from staff nurses also responded by just doing the minimum. Elizabeth described how a nursing student who had been accused by a staff nurse of pulling out a nasogastric tube of a patient on an intensive care unit responded to being treated with incivility, "She was very quiet. Very quiet, kept to herself. Just did what she needed to do, and that was it." Being unfairly blamed by staff nurses is hurtful to students and can lead to anger (Thomas & Burk, 2009). Students in Thomas's (2015) study remained cordial to a nurse having a patient care issue and also informed their clinical faculty about the issue to avoid being blamed for unsafe practice.

Staff nurses responded to incivility from their colleagues or nursing students in different ways. They either ignored the uncivil nursing students, reported staff nurse incivility to a superior, or did nothing at all. This study revealed administrative staff rarely responded to the uncivil behavior of staff nurses, addressing a gap in the literature as to why incivility continues to persist. Additionally, a stunning finding from the Workplace Bullying Institute (2017, July 7) found 65% of bullying stopped when targets resigned from their employment; only 10% of employers addressed bullying behaviors.

When incivility took place between staff nurses and students the clinical faculty took over communication with the nurse. An example of this type of situation occurring on a medical-surgical unit was provided by Jan, "The instructor just kind of took over the issue . . . whenever there was a conversation that had to take place, she kind of just stood in for that nursing student with that nurse." Carrie, a staff nurse who was precepting a nursing student who had exhibited unprofessional behavior, explained how she responded to this situation, “I tend to deal with it by not dealing with it, not confronting them.” She also responded by informing the clinical faculty about the behavior and reflecting the student’s behavior on a clinical evaluation form. Similarly, Norah not only ignored nursing students who were uncivil, but refused to offer them help when students needed it.

A significant finding in this study was the majority of participants who were unaware of hospital policies regarding hospital policies. Of these participants, clinical

faculty were more aware of their educational facilities' policies. Rose's statement illustrated clinical faculty being more familiar with school policies than hospital policies: "We do at school B [have policies regarding incivility], but at the hospital, I don't know, I don't think so. . . . I can say at the school where I do work does have the incivility policy, specifically stated in the handbook." Rose attributed not knowing hospital policies because she seldom had to refer to them. Trudy was a staff nurse who was unaware of policies regarding incivility; she stated, "I've not heard anything with nursing. It may be there, but no one's ever told me about it." These findings indicate a need for healthcare facilities to educate both staff and clinical faculty about behavioral policies.

Most staff nurses in this study were unaware of hospital policies regarding disruptive behaviors like incivility. Elizabeth's response mirrored those of most of the participants when asked about hospital policy: "Gosh. I don't really know. I don't think that they [management] implement a lot of those. . . . I don't really know what exactly the policies are. I think a lot of times they're [management] pretty complacent with them." This finding also addressed a gap in the literature of why incivility continues to plague nursing units. Only two participants could discuss their hospitals' policies regarding unprofessional behaviors. Norah said, "There is not an actual policy that says 'incivility.' We have behavior policies." She specified, "Lateral violence policies and bullying policies." Joe referred to the code of conduct and how it was enforced on an annual basis. Joe mentioned the consequences for violating the code of conduct as "anything from a reprimand, up to and including termination." Overall, this finding

evidenced an educational need for staff nurses of healthcare organizations. Nurses must know workplace policies that address professional behaviors to successfully address horizontal violence (Becher & Visovsky, 2012).

Civil work environments within hospital settings can only be achieved by nurses uniting and abiding by the *Code of Ethics for Nurses* (the *Code*) (Ditmer, 2010). The majority of participants discussed the importance of the *Code* while also acknowledging a lack of application of its principles. Participants acknowledged that it is rarely, if ever, thought about in day-to-day nursing practice. Alaina highlighted an important issue: "I've never discussed the *Code of Ethics* with other nurses. I've never had that discussion peer to peer on a unit. My personal belief is sometimes more academic ideals fail to make it to the clinical setting." Likewise, Jan admitted:

> I don't even think that nurses . . . once they're out of school, they never even think of that. . . . It's never anything that nurses even discuss. I don't even know if it's in their mind at all.

Nurses need to recommit to the *Code*, for it encourages nurses to treat others with dignity and respect (Martel, 2015).

Some participants discussed their personal ethical nature in the context of ethical nursing practice. Charlotte stated, "I think I live by the *Code of Ethics*." Likewise, Myra said, "I try to be ethical. I try to think about the *Code of Ethics*. . . . I think it just comes from my moral being, just from who I am as a person." Myra described her awareness of the *Code*:

> I can't quote you the *Code of Ethics* right now, but I try to just as a person, be an ethical, moral person. I know what the *Code of Ethics* are but I can't say they're in the forefront of my brain.

Jennifer provided insight into ensuring future nurses are aware of how to apply the *Code* to practice:

> You can review the *Code of Ethics* with the students, and you can follow the *Code of Ethics* yourself, and all I can say is that the students have to see it in order to understand how it applies to them being a professional nurse.

Myra's statement provided a good summary to this issue, "The nurses' *Code of Ethics* . . . does speak to how nurses should behave and approach this profession. And I do think there is a lack of knowledge in regards *[sic]* to that, in the nursing profession and overall." For nurses to have ethical work environments in which to work, they must be knowledgeable of the *Code* and healthcare facilities must have clear policies and procedures regarding professional conduct (ANA, 2015a). Additionally, as obvious as it may sound, nurses have a duty to abide by ethical codes of conduct (Ditmer, 2010).

Of all the behavioral guidelines available to registered nurses, most participants were aware of the code of conduct within their facilities. However, my study found codes of conduct alone were ineffective for addressing uncivil behavior. Elizabeth's statement illustrated one possible reason for the ineffectiveness:

> I'm not sure that when people are being uncivil to one another that they're thinking about the code of conduct. I think it may make them be a little bit more restrained knowing that they could get fired for acting out in certain ways.

The reasons given for the persistence of incivility and other unprofessional behaviors, despite having a code of conduct, were a lack of enforcement and a shortage of nurses. Jan was a staff nurse on a medical-surgical unit and described the effectiveness of the code of conduct: "You would have to be almost physical with someone before they would actually step in and start firing you. . . . You can't just snip at somebody and get in trouble." Norah noted that to be effective, consequences have to be enacted to curb unprofessional behavior. However, she identified a perceived barrier to administrators' implementation of consequences for policy violation:

> The code of conduct itself, really doesn't have too much of an effect. Whether there are consequences, has an effect. . . . You can be relieved of your duty, you can be reassigned type of deal. It's not really carried out too much because we're short [of nurses].

I asked two clarification questions to be sure I understood her correctly: "So due to the shortage of nurses, people are less likely to be terminated from their employment because they're needed? So, we tolerate uncivil behavior in the unit because we can't afford to lose them?" She responded, "Yeah, pretty much." Responses by these participants indicate a need for institutions to combine policies with interventions for decreasing incivility, as suggested by Magnavita and Heponiemi (2011). Researchers of incivility have also recommended administrations educate employees about their code of conduct (Anthony & Yastik, 2011), however, my study found administrators should also administer consequences when policies are breached. Additionally, all nurses need

to be committed to creating healthy work environments by holding their colleagues accountable and evaluating nursing students on behaviors essential to civility (Luparell, 2011).

Subtheme: "Pray for us." Five participants talked about the toll of returning to negative environments where incivility had taken place. When uncivil encounters were not quickly resolved registered nurses had to return to the uncivil environments they dreaded. As the subjects in Schön's (1983) study were repeatedly exposed to errors in balancing the blocks, they used knowledge from previous successful and unsuccessful attempts to try to successfully balance them which was termed a "theory-response." Similarly, these nurses were developing their theory-responses by repeated exposure to successfully manage uncivil students. Nurses described the difficulty of returning to these environments, however, clinical faculty had a professional obligation to complete clinical education for nursing students. Staff nurses described dreading uncivil nursing students from certain schools of nursing.

The anticipation of encountering incivility created a sense of dread for participants. As revealed in this study, where incivility is present people would rather be absent. However, these situations were often beyond participants' control. Norah described how she dreaded BSN students who treated her as irrelevant after assuming she only had an associate's degree. She added, "With the ADNs, there was incivility there too, but theirs was more on the . . . just more of you're just in their way." Referring to the nursing student she was precepting, Rose let her supervisor know that

"I cannot babysit at 7:00 in the morning." Myra and Hope seemed to be more deeply affected by their encounters. During a clinical post conference, Hope was treated with incivility by the majority of the nursing students after presenting them with assignment guidelines. She recalled how she responded to her students' incivility:

> I tried to hurry through going through the rest of the rubric, and then just ending post conference there. I wanted to leave. . . . I was just taken aback that this was some of the worst experiences I ever had, in terms of incivility. I remember just dreading clinical, not wanting to go, driving to clinical and just praying and asking other people to pray for us because it just felt like I was going to battle when I would go to clinical.

Myra's uncivil encounter with a nursing student, while she was pregnant, took a heavy toll on her. During the encounter, the student had thrown and hit her with a plastic soda bottle. She explained, "It got very personal. I just kind of lost emotional control and just started sobbing, because I also started cramping. . . . I was just scared and sad about my pregnancy at that point, so it was just really hard." In the aftermath of her encounter, rumors began to circulate among Myra's students that she was the instigator of this uncivil event. She hurtfully recounted:

> How have these people known me and they would actually think that I would do something like that? It was just incredibly hurtful that my integrity and professionalism, and just who I am as a person would be called into question in that regard. That was what bothered me the most, once I got over the fact that my child could have potentially been harmed in that situation. That was the hardest thing for me to overcome.

Myra chose not to set the record straight, instead she said, "I just wanted it to go away. I just wanted it to end." These findings were consistent with students in Martel's (2015)

study that found experiencing incivility at clinical caused them to feel anxious and stressed to the point of dreading clinical.

The findings of this theme helped to addressed several gaps found during the review of literature. One gap addressed by this theme was in regard to the continuing plague of incivility within hospital's acute care settings. This theme also described staff nurses' experience of incivility during clinical education. A third gap addressed by this theme was discovering what staff nurses perceive as contributing to the perpetuation of incivility in hospital settings. These findings also augmented the understanding regarding what knowledge registered nurses have of the *Code of Ethics for Nurses* and what prevents implementation of its principles. It is acknowledged that this is a small sample size, however, the understanding of these areas was enhanced.

Theme Three: Aftermath of Incivility

The theme *aftermath of incivility* captured what registered nurses' lives were like once the uncivil event was in the past. Positive and negative findings were revealed from registered nurses' descriptions. Positive findings included finding satisfaction in their job role again, the lessons nurses learned from these encounters improved their ability to manage these situations in the future, and strategies were developed that could offer support for staff nurses, clinical faculty, hospitals, and educational institutions in preventing or successfully managing future uncivil events. Negative findings included the consequences of incivility for patients, nursing students, registered nurses, administrations of both hospitals and educational institutions. The subthemes

for *aftermath of incivility* included: a) *"leaving a scar,"* b) *"do not hire,"* c) *relieving the pressure,* d) *creating student awareness*, e) *engaging the student,* f) *"a teaching moment,"* g) *"reflecting,"* and h) *"coming back to life."*

Subtheme: "Leaving a scar." Five participants described how experiencing incivility is like *"leaving a scar."* They discussed how they are able to recognize individuals, particularly nursing students, who have experienced incivility. They delineated the lasting effects of incivility and how those who have experienced incivility may be affected by that encounter in the future. As their descriptions revealed, acts of incivility inflict harm on individuals and can leave lasting effects. As noted by Schön (1983), tacit knowledge results from reframing problems based on past experiences; therefore, if incivility has been experienced in a clinical setting future experiences can be affected.

Typically, nursing students are excited, yet nervous, when they arrive on nursing units for clinical education. When nursing students experienced incivility from registered nurses, it affected their willingness to interact with them, thereby negatively affecting potential learning opportunities in the clinical education environment. Trudy described nursing students who had experienced incivility from staff nurses on her medical-surgical unit:

> It is like leaving a scar on that particular student. . . . If the student approached you and that student says you make that student feel like they're bothering you, that student's going to be afraid to bother, that they're going to bother you next time. . . . They're afraid to make that initial approach.

Hope described how nursing students felt when staff nurses would not incorporate them into the patient care they were providing, “Unwanted. Then, they lose that excitement when they first step onto the floor, and they just generally want to stay out of the nurse's way and then they hesitate about walking into those patients' rooms.” This finding was contrary to Randle’s (2003) discovery of bullied nursing students who tried to fit in with staff nurses in order to get positive responses. Anthony and Yastik (2011) explained how students feel excluded by the team when nurses do not welcome them.

Experiencing incivility in the clinical education environment inhibited the learning of nursing students, potentially affecting future interactions with staff nurses. Nurses described the countenance of students who had experienced incivility. After being falsely accused of pulling out a patient’s NG tube in the ICU, which resulted in a poor evaluation, a nursing student on Elizabeth’s intensive care unit was visibly upset and no longer sought out learning experiences. The student’s response to experiencing incivility from the staff nurse was described by Elizabeth:

> She was scared to death [laughs through statement]. She was very upset. . . . Her attitude, and her facial expressions. . . . Just very demeaned. Just looking down, and scared, tears in her eyes. . . . She was very quiet. Very quiet, kept to herself. Just did what she needed to do, and that was it.

Students in Thomas and Burk’s (2009) study found it hurtful to be unfairly blamed by staff nurses, which led to anger. Negative clinical experiences can cause negative repercussions on nursing students’ self-esteem (Randle, 2003).

Staff nurses also described how they could tell nursing students who had experienced incivility by noticing their appearance. Trudy saw students on her nursing unit who "looked scared and . . . overwhelmed." Norah said, "Sometimes I feel like they've been treated some way because they'll have that look of 'oh my god.'" Not only were students affected individually, but they were also affected as a group. Melanie discussed her clinical group of students who experienced feeling welcomed on a nursing unit for the first time:

> I teach on a unit now for critical care, and the students often come to that unit and say, 'This is the first unit that I have felt welcomed in the entire first year and a half of my program.'

Likewise, Hope described how students felt encouraged by the nurses on her clinical unit:

> That was a big thing they kept mentioning. How the floor functioned, how they felt accepted by the nurses, how even the nurse manager and the nurse educator took time out of their day to recognize them and show them some of the equipment specific to that floor. They really felt the difference between the other floor they were on, and then this floor where the nursing staff was more encouraging of them and actually liked having nursing students on the floor.

BSN students in Anthony and Yastik's (2011) study felt eager and excited when nurses included them in patient care which led them to seek out more learning opportunities.

An element of the aftermath of incivility described how *the patient suffers.* It is known that disruptive behaviors prevent effective patient care (Hutcheson & Lux, 2011). However, this finding was not supported by the conceptual framework for this study. Most participants' descriptions revealed how *the patient suffers* when incivility is

occurring or has occurred. Incivility was found to be a distraction on nursing units, shifting the focus from the patients to either the participants in the uncivil encounter or a discussion about the uncivil event. Myra, a clinical faculty member, described how her uncivil encounter with a nursing student on her clinical unit distracted nurses from patient care, "The patient ultimately is the one that suffers. . . . Even on that day the nurses were distracted by what had happened with me. And so, the patients weren't being cared for." Jan detailed how a nurse could overlook important patient findings after encountering incivility in a hostile work environment:

> Your emotions are gonna *[sic]* guide you more than your brain, your thinking processes. You're gonna *[sic]* be too wrapped up in, my feelings are hurt. . . . You're missing that maybe they didn't put out much urine that day and they're going into multisystem organ failure or something. . . . I can see where you would, if you're feeling too emotional, not paying attention to your medications and give them the wrong med.

Incivility can cause the patient to suffer due to a lack of communication, consistent with the findings of Anthony and Yastik (2011) in which they found gaps in communication could cause patient harm. In my study, negative emotions stemming from uncivil interactions caused staff nurses and nursing students to avoid asking one another for help or to clarify misunderstandings. Norah described how incivility affected patient care on her medical-surgical unit:

> On a nursing unit, being uncivil leads to you just not communicating. . . . You don't feel comfortable . . . approaching that person, or somebody approaches you and you don't feel comfortable with them approaching you, so you give off that vibe of, 'Oh yeah, do not talk to me.'

Ineffective communication due to incivility can lead to errors in patient care (Anthony & Yastik, 2011; Joint Commission, 2008). Norah explained how a lack of communication affects patient care, “Things don't get done, or they don't get done well and things are at risk.”

Subtheme: “Do not hire.” The subtheme *“do not hire”* compiled five participants’ descriptions of different types of negative consequences incurred by nursing students who perpetrated incivility. Attending clinical on nursing units provides nursing students with opportunities for their skills and professionalism to be witnessed by the staff and managers of these units. Along with the potential to fail nursing courses, uncivil students also faced the potential consequence of not being hired by the hospitals where they completed their clinical education. The negative consequences of incivility within this subtheme were supported by Schön’s (1983) reflection-in-practice theory. When experiences are not reflected upon, nothing is learned from the experience to affect change within future experiences.

One negative consequence that uncivil students incurred was clinical instructors or nursing staff who recommended *“do not hire”* that nursing student. A major implication discussed by three registered nurses regarded employability of uncivil nursing students. Unprofessional, arrogant attitudes were undesirable qualities in potential coworkers. Rose was a clinical faculty member who offered to be a reference for students seeking employment after graduation. She described addressing a job reference for an uncivil student, "He [an uncivil nursing student] had put me down for a

reference . . . I only had given two bad ones. I've given a lot of good ones. I told her, uh-uh do not, do not hire him." Norah described her perceptions as a staff nurse of seeing previous nursing students who had behaved uncivilly on her nursing unit applying for a job on her nursing unit, “You see them later because they like come on the floor because they need a job. And you’re like, ‘Yeah, don’t.”

A second negative consequence was on uncivil students’ nursing education. Nursing students who behave unprofessionally on nursing units are usually held accountable on clinical evaluations forms. Students can fail to meet the criteria for passing their clinical experience, usually resulting in clinical failure and subsequent course failure. A nursing student argued with Charlotte, a clinical faculty member, about the negative feedback she received regarding patient care. Charlotte revealed “she did end up failing clinicals” as a result of multiple unprofessional behaviors. Myra encountered two uncivil students who ultimately withdrew from the nursing program.

Subtheme: Relieving the pressure. This study revealed the pressures felt by registered nurses within organizations and healthcare environments which were found to influence uncivil actions in clinical education environments. Six participants offered strategies for *relieving the pressure* that can help administrations mitigate hostile work environments in hospital settings, thereby creating more civil learning environments for nursing students and improved patient safety. Strategies were related to increasing nurses’ availability to patients, having adequate staffing and supplies, increasing administrators’ awareness of staff needs, and ensuring administrators held staff

accountable in establishing policies and procedures. Relieving the pressure of staff nurses can decrease the stress that leads to disruptive behavior (Walrath et al., 2010). As depicted in the conceptual model by Clark and her colleagues (2011), implementing successful strategies in high-stressed environments can lead to a culture of civility.

Nurses expressed a desire to have more time to focus on patient care. Requiring registered nurses to perform tasks not directly related to the care of their patients created a lot of pressure for participants who wanted to be more attentive to patients' needs. Additionally, not having appropriate amounts of supplies and equipment has been shown to create hostility among nurses, which can compromise patient care (Thomas & Burk, 2009; Walrath et al., 2010). Jan spoke passionately about how organizational pressures could be relieved to help decrease incivility:

> Let nurses go back to doing core nursing. Bedside nursing be bedside nursing. Take away all the extra pressures. If the physicians aren't doing some of the things that they need to do to get their core measures completed, that should not be on nursing to make sure the physicians do that. That should be on administration or other physicians to police them. It should not be up to nursing.

Jan became visibly passionate about this discussion. She declared, "Gosh, I feel frustrated talking about this." She continued by describing how administration could help decrease incivility in hospital settings: "Have things available that we need. Don't make nurses have to fight over equipment. We shouldn't have to fuss over, 'How many IV pumps are on your floor?'" This concern was congruent with Randle's (2003)

statement that uncivil environments with high demands and limited resources must be reformed to prevent the spread of incivility.

Sufficiently staffing nursing units can reduce some of the stress experienced by registered nurses. Understaffing was found to be a large contributor to uncivil actions. Elizabeth, who had worked in an understaffed intensive care unit "for years," suggested:

> Do what they [administration] need to do on their end to open up job positions and to hire them, to actively pursue people's resumes that have been submitted, to actively look for people to cover shifts, and that kind of thing.

Jan talked about workload contributing the negative culture of her workplace while noting, "Changing a culture is hard. It is very, very hard. It's almost a culture of that whole facility." Nurse managers can influence the culture of work environments and affect the morale of the staff. Consistent with views of D'Ambra and Andrews (2014), when incivility becomes a part of practice environments a cultural change is required by the profession and healthcare facilities should not accept this behavior as normal. Randle and Stevenson (2007) reported key administrators can change a culture of behavior by enforcing intolerance of disruptive behaviors.

Two factors for increasing registered nurses' job satisfaction were found: when registered nurses perceived their work was valued and when less incivility was present in the work environment. Melanie described how her previous managers made her feel valued as an employee:

> Those that take the time and make a point to get to know everyone and make sure that they're satisfied. . . . People are satisfied by just being or felt like they're being encouraged . . . being valued.

Melanie suggested this strategy for administrators:

> Being consistent with celebrating those under them. So not only celebrating a handful of people and their achievements, but make sure you celebrate everyone and all of their achievements and just taking time to get to know what they're doing.

Carrie did not feel valued by her administration. She talked about how registered nurses at her healthcare facility were mandated to be preceptors for nursing students. She suggested how her facility could make this mandate more satisfying for nurses:

> Some kind of reward or incentive . . . recognition for taking students. But there seems to be *[sic]* it's just an expectation; there's no reward or no recognition for all of the work and extra effort that goes into having a nursing student with you. The facility seems to let that go unrecognized.

Nurses should be rewarded for being positive role models for nursing students as a way to decrease incivility in the clinical education environment (Anthony & Yastik, 2011).

A lack of administrative support was presented in theme one. Participants described many attributes of supportive administrators, including having open communication, demonstrating strong leadership, being approachable, and valuing their nursing faculty and nursing staff. These characteristics are consistent with the findings of a quantitative study by Hayhurst, Saylor, and Stuenkel (2005) in which the characteristics of managers staff nurses valued included "a nurturing leadership style, physical presence on the unit, supportive attitudes toward staff problems, a willingness to address issues, and the ability to resolve nurses' issues and concerns" (p. 287).

Having open communication and being approachable made it easier for nurses to discuss clinical issues. Approachable administrators increase nurses' job satisfaction (Hayhurst et al., 2005).

In this study, being approachable was a recurring attribute associated with supportive administrators. Some participants described their administrators as though they were a mentor from whom to learn how to handle difficult situations. Rose described her approachable administrator as someone she could learn from through verbal interactions:

> I talk to her probably every day about work. Just having that back and forth and communication. . . . 'Hey I wanted to talk to you about this,' or 'Hey I want to talk to so and so today about this issue. This is a couple of ideas. Does that sound reasonable?'. . . She's a wealth of knowledge, she's very experienced . . . just a dear leader. . . . She's very approachable.

Similarly, Myra felt supported by having open discussions with her administrator from whom she perceived was working on the behalf of her faculty members:

> I would just go in and I would just sit in her office for a long time and talk to her. . . . I just feel more comfortable with her and genuinely love her. . . . she's working so hard for us. . . . It's really just a personality thing. I just find our current director to be more approachable.

Administrators' supportive attitudes toward nurses who are facing problems is a characteristic valued by nurses (Hayhurst et al., 2005). Both Rose and Myra perceived their administrator "has my back." Rose added, "You should go to your manager and they should always welcome you in."

Supportive administrators were described as being familiar with their staff, valuing the work of their employees, and working to maintain staff satisfaction. These types of administrators made time to visit the nursing units they managed and talked to staff members. Melanie described her supportive administrators as "the best managers that I've seen are those that take the time and make a point to get to know everyone and make sure that they're satisfied." She explained what she meant by satisfied: "Feel like they're being encouraged. They're being valued. People don't mind the hard work as long as they feel like their work they're doing is valued by their administrator." Melanie suggested administrators could find "some kind of routine so you can be present and visible and show people that you value what they do." She illustrated this suggestion by describing a supportive nurse manager she worked for:

> One thing that she did a great job to keep morale up of the organization is she used to come in and exercise at five a.m. in the morning, and she would come through her unit, and then go exercise. It finally occurred to me that she did not have to get up at five to go exercise, but she made a point to do that so she could always see the night shift and make sure she was visible and check with every member of her team.

Administrators who are present, visible, and approachable have been shown to increase nurses' sense of support, thereby increasing job satisfaction of nurses, which in turn improves quality of patient care (Hayhurst et al., 2005).

Administration should hold all employees accountable to established policies, procedures, and codes of conduct. Nurses in this study felt a lot of pressure when their colleagues either did not show up for their shift or who displayed incivility in the work

environment. Participants desired managers who would not only hold employees accountable to established policies but would also address the behavior as close to the uncivil event as possible. This is congruent with Walrafen and colleagues (2012) who found nurses want managers to hold perpetrators of disruptive behaviors accountable. Carrie explained, “The [uncivil] incident should be addressed as quickly as possible so that it doesn't happen again.” When incivility occurs between certain members of the staff, these staff members should not be consistently assigned to the same group of patients. Norah found patient care suffered when she was assigned with the same people with whom she had experienced incivility, "It depends on how much management gets involved . . . you don't have to be assigned with the same people all the time." Carrie described the length of time it took for issues of incivility to get addressed:

> A lot of times no immediate action is taken. It's not brought up until you have your yearly review. . . . I guess if it's something severe or bad enough then the next shift that you work it would be addressed, but a lot of times it was not addressed immediately.

These findings address a gap in the literature because they identify recent, successful strategies registered nurses have used to mitigate incivility as well as barriers to implementing strategies. To further improve clinical education environments, I recommend stakeholders of nursing education and healthcare facilities study the implementation of the strategies delineated here.

Subtheme: Creating student awareness. As previously discussed, nursing students unaware of how nursing units function influenced uncivil actions. Therefore, the subtheme *creating student awareness* presents how nurse educators can make nursing students more aware of these nuances prior to entering clinical settings. Suggestions included clinical faculty workload, preparing students for nursing education, educating nursing students regarding incivility, location for pre and post conferences and reading of patients' records, and additional ways to reduce influences for uncivil actions. Findings that illustrate this subtheme are supported by the model of Clark and her colleagues (2011) that suggested students should be equipped with skills that foster a civil practice environment.

General recommendations for nursing education were offered by registered nurses in this study. Clinical faculty workload was discussed by several participants, including staff nurses. Faculty workload was identified in Clark and colleagues' (2011) conceptual model as contributory to adverse working relationships with nursing practice. Norah illustrated how the number of nursing students assigned to a clinical faculty appears on clinical units, "You've got these students who are wet behind the ears. . . . They've got an instructor, but there's like 50 million of them, she can't follow them all." Trudy suggested students spend "a day with a nurse" to help "expose students to more, to give them an opportunity to really see what nursing is."

Educating nursing students about certain issues prior to their clinical education experiences was suggested by several registered nurses in this study. The primary

educational issues were educating nursing students about incivility, including the use of simulation for both faculty and students. Other issues included teaching students how to manage their time and stress. Three participants referred to the need for nursing students to be educated about incivility, including the consequences for exhibiting these types of behaviors and how to address incivility if they encounter it. Randle and Stevenson (2007) agreed that students who have the potential to face incivility should be prepared with effective ways to address it. However, nursing would be better served by preventive interventions (Thomas & Burk, 2009) because any uncivil experience can be harmful.

Preventive strategies included educating nursing students about incivility and its consequences. Jennifer presented a strategy to help prevent incivility between clinical faculty and their students:

> Faculty and administrators need to address it in the beginning, during orientation. . . . As students feel entitled . . . it can increase that incivility. . . . Make it an assignment for them to research the topic and discuss it in a classroom.

Likewise, Anthony and Yastik (2011) suggested incivility should be discussed with students in the classroom or during clinical conferences.

The importance of educating students about incivility and how to incorporate the *Code of Ethics for Nurses* into their practice could protect the future of the nursing profession. Jennifer stated, "If students don't know how to conduct themselves based on a code of ethics, then it's gonna *[sic]* tarnish the nursing profession." Students

should also be made aware of behavioral policies prior to arriving to clinical to better understand the professional behaviors required for safe patient care. After encountering incivility during a nursing student's preceptorship, Carrie offered this advice for nurse educators in preparing nursing students for these experiences:

> The nursing school, with the students, the standards, and what's expected of the student should be more clear *[sic]* with the student before they come to the facility . . . those standards should be discussed with the precepting nurse before the student comes to make sure that there is a positive relationship and that both parties understand what is appropriate and inappropriate.

Anthony and Yastik (2011) also encouraged faculty to inform students about behavioral policies of healthcare facilities in which clinical education takes place.

Simulation in schools of nursing has become an effective teaching strategy in nursing education. Melanie, a clinical faculty, recommended using simulation for both part-time faculty and nursing students to encourage education about incivility and how to manage these occurrences:

> We can try to teach students and make sure they're demonstrating professional behaviors in the simulation area, so hopefully that will translate to the clinical setting. . . . We've done, in the past, where the clinical instructors go through a simulated experience . . . with standardized clinical students. They would . . . do something like crazy unprofessional . . . in front of the instructor. . . the adjunct instructors would have an opportunity to try to address those issues . . . in a professional manner.

Simulation activities involving conflict resolution should be included in nursing curricula as well (Anthony & Yastik, 2011). Even with educational strategies like these, Melanie

pointed out, “It’s going to be hard to correct it [uncivil behaviors] in the clinical setting, but hopefully we can do a better job to correct it in the simulation area.”

Helping nursing students understand how nursing units function was important for most participants. They discussed the need for students to know how to behave and where to go during their allotted clinical time. Trudy contrasted two clinical faculty she has seen on her nursing unit:

> I’ve seen them come in and basically, ‘You go over there and you go over there,’ just disperse the students to the nurses. . . . We have one now . . . and I just love it . . . she sits there on her computer and she goes down, anything they need to talk to them about their patient, she does an assignment. She talks to them about their patient and then they come out with the nurses.

Rose described how she acclimates her students to a nursing unit:

> I do my best to make my students aware of . . . and show them places where they can go. Here’s a room . . . here’s a computer people don’t really go to, so if you do go sit down sit here. . . . I have kind of tried to . . . make way to try to break down some of those barriers.

Staff nurses’ disinterest in educating nursing students was noted throughout the narratives. Some staff nurses did not have the personality for teaching them. This has been present in the nursing profession for decades (Amann & Williams, 1960). In light of this, participants discussed considerations for clinical faculty when making nursing students’ patient assignments. One consideration was for clinical faculty to determine which staff nurses are amenable to helping educate nursing students. Elizabeth pointed this out when discussing a staff nurse who wrongly accused a student of wrongdoing:

"That nursing student could have experienced whatever was going on with that patient with someone who was more open to teaching."

A second consideration was once assignments are made, clinical faculty should facilitate introductions between staff nurses and nursing students. As Trudy pointed out, "They're [nursing students] afraid to make that initial approach." Norah found nursing students "were more likely to acknowledge you as somebody relevant" when clinical faculty introduced the student to the nurse assigned to a patient. Norah also provided a suggestion for students' communication with staff nurses, "This is the nurse for that patient. Make sure that you report off to that nurse. Be sure you tell that nurse what it is that you're doing. And use the nurses as your resources."

Once clinical faculty have introduced nursing students to their staff nurses, students may begin patient care. A third consideration was that clinical faculty should explain to students when it is inappropriate to interrupt nurses with questions, for example, during medication preparation and while the nurse is focused on patient care. The instructions provided to nursing students by their clinical faculty made a difference on perceived incivility on Norah's nursing care. She stated, "If there was a difference, it had to do more with the instructions they [clinical faculty] gave the students specifically."

A fourth consideration noted by registered nurses was to allow nursing students time to review skills with a nurse before entering patients' rooms. In this study, the chance of incivility occurring at the bedside increased when students were anxious

about performing a new task, which contributed to incivility. To mitigate incivility at patients' bedsides, Alaina described a strategy she used to help increase student confidence and decrease stress:

> Before you start a task . . . before we ever entered the room, we assured we had all supplies together. 'Is there anything that you want to walk through again before we enter the room? Do you have any questions?'

Similarly, Trudy discussed how she affords students the opportunity to go in a private area and "go through the steps" of a procedure that the student is about to attempt at the bedside.

A fifth consideration was making students aware of the behaviors that can result in a poor evaluation. As previously reported, clinical faculty are more likely to encounter uncivil student behaviors when providing negative feedback. Creating this awareness can decrease the risk of incivility two ways. First, it can prevent students' surprise when a poor evaluation is received. Charlotte provided an illustration of how she usually handles student feedback and evaluations in a manner that decreased her experience with incivility: "I try to tell students when the event occurs, 'You're getting an unsatisfactory for this.' It wasn't like it was a surprise." Secondly, if students are aware of the behaviors associated with a poor evaluation, then perhaps students will avoid those behaviors. Hope discussed how she and her co-faculty increased professionalism of clinical students:

> We really discussed those aspects and penalized students when they weren't doing what they were supposed to be doing, and so I think with that, we were able to establish really a picture for the students of what

> and how they should act towards faculty, towards patients, towards other nurses or medical disciplines that they work with.

A sixth consideration offered by a majority of registered nurses regarded a lack of support from administration. Some participants suggested administrators receive specialized training in either hospital settings or as part of their graduate education. Jennifer had described how administration sided with a student who had perpetrated incivility instead of with Jennifer, the clinical faculty. She had this recommendation for those responsible for educating nurse leaders:

> The curriculum that is training nurse leaders to emphasize more on the code of ethics and understanding what leadership is and how to support your staff. . . . How do you support your staff as leader? Write case scenarios so that nursing leaders can just reflect on possibilities of what they can do, what they should do if they ever get in those positions.

Subtheme: Engaging the student. A couple of issues were identified from participants' narratives that were found to influence uncivil actions. These issues pertained to nursing students' lack of exposure to nursing environments and how registered nurses' interactions affected students' experiences. Nursing students are under a lot of stress during clinical education. Some have not been exposed to working in hospital settings. Therefore, they are usually unfamiliar with the routines and rituals of nursing units as well as the routines of registered nurses. Subsequently, they do not always know how to act, who to approach, or what is permissible unless instructed.

Another issue was registered nurses not recognizing the importance of engaging students who may feel lost in these new environments. When incivility arises out of

these situations, registered nurses need to be aware of how to respond on behalf of the students. The subtheme *"engaging the student"* captured the strategies offered by four participants that address these concerns. Implementation of these strategies can prepare registered nurses to mitigate incivility during clinical education and create a more civil learning environment for nursing students.

Nursing students new to hospital settings can be overwhelmed by new clinical experiences and the unfamiliarity of how a nursing unit functions. Those who have experienced incivility may be less likely to take the initiative for learning opportunities on clinical units, as previously discussed and delineated by several authors (Hutcheson & Lux, 2011; Martel, 2015; Thomas, 2015). Registered nurses, being the experienced professionals on nursing units, can make students feel more comfortable in the clinical environment by *engaging the student*.

A few staff nurses in this study were able to notice stress and anxiety in nursing students and took the initiative to "invite" them to patient care. Trudy shared what she has learned from working with nursing students who have had clinical experiences on her medical-surgical unit:

> I don't think that the student . . . will seek out opportunities to learn more, touch more, and do more. . . . They're really standoffish and sometimes you have to go get them. I think it may be because of maybe things that happened to them in doing the nursing process. . . . It creates a little anxiety for them.

Norah explained how she first interacts with nursing students on her medical-surgical unit, “Usually I try to speak, ‘Hey.’ Introduce myself as the nurse for that patient . . . to kind of let them know that I’m a resource and that’s my patient.”

Registered nurses should take time to teach less experienced nurses and nursing students in a civil manner. Jan explained, "You want to teach them so that they become good nurses, and you don't wanna *[sic]* do that in a way that makes them feel like they've gotta *[sic]* quit or they're frustrated." This and other findings in this subtheme provide evidence that demonstrates how stress is managed by nurses in practice and students in nursing education within stressful environments can lead to a culture of either civility or incivility. These findings support the conceptual model by Clark and her colleagues (2011).

Subtheme: “A teaching moment.” Participants’ narratives revealed two different outcomes can emerge when uncivil events occur: The educational essence of the event can be lost, or it can become *“a teaching moment*” for prevention of incivility in the future. This subtheme captured participants’ descriptions of using uncivil encounters to educate stakeholders of healthcare facilities about incivility. In the clinical education environment, frustration of experienced nurses with less experienced nurses and nursing students was a significant finding leading to incivility. Jan described a moment where experienced nurses reacted with incivility while working with less experienced nurses:

> The other nurses [more experienced] are frustrated because they [less experienced nurses] make a lot of mistakes that the following nurses have to fix. There is so precious little time to fix so then they snap. They snip at them, 'You did this, you did this,' instead of letting it be a teachable moment. They just snap out in anger.

In contrast, participants gave accounts when the potential for incivility was present, but a teaching moment transpired. Norah perceived incivility from a nursing student who had not acknowledged her presence during half of her shift. Noticing the student was struggling with a dressing change on Norah's patient, Norah explained a conscious choice she had to make:

> I can either let you finish whatever it is that you're doing and . . . have to go back in there and change it, or I can go in there . . . 'Hey, I'm Norah and I actually have this patient, and I put the dressing on that was on before. Let me give you a few tips on how to get those gauze on and how to get that to stay on and what you need to do to get the dressing change happening short of me actually doing the dressing change.'

Joe shared how an uncivil encounter became *"a teaching moment"* for the entire healthcare facility. A nursing student and her clinical faculty became belligerent while defending a medication error they had created earlier in the day. After the hostility of the situation was resolved, both the clinical faculty member and the nursing student apologized to the staff and administration for their behavior. Joe, the administrator who helped manage the uncivil situation, explained the teaching moment:

> It was an opportunity for this particular student to learn that the hour of sleep has designated time frames to it. So, there was a sort of a teaching moment in it, both for that student and for that faculty member, and I can say that the student seemed to grasp the situation.

An additional "teaching moment" for the healthcare facility was described by Joe:

> I was able to share with a nursing management team at our facility that this had occurred, and it was something that was teachable to everyone there. . . . I was able to share that experience with the other members of the healthcare team, and hopefully to have that not transpire again.

Subtheme: "Reflecting." Many participants described what they learned after *"reflecting"* on their experiences with incivility, revealing the essence of those experiences. The subtheme *"reflecting"* encompassed what some of these participants would do differently "the next time around." When participants reflected on their uncivil encounters, they learned what did not work successfully to resolve the situation, which helped them determine what they would do differently, what Schön (1983) referred to as knowledge-in-action. Actively reframing problems based on past experiences develops tacit knowledge to help one solve present and future problems the next time they are encountered (Powell, 1989; Schön, 1983). After reflecting on their experiences, seven registered nurses described mostly regrets about the decisions they made related to their encounters with incivility, however, they also discussed what they learned from those experiences that will improve their future practice.

Clinical faculty who experienced incivility with nursing students described what they learned from these encounters and the different ways they will address it in the future. Three areas that clinical faculty would treat differently in the future involved privacy when counseling students, presence of nursing students on clinical units post uncivil encounters, and response to nursing student incivility. All participants provided

privacy when addressing incivility with the perpetrators. This was mostly done out of respect for the nursing students to prevent embarrassing them. One participant decided after her encounter to always be visible and in earshot of nursing staff. This decision probably arose from incurring physical violence. Myra chose to meet with an uncivil student in a private room to discuss his behavior out of concern for his privacy. She admitted, "I regret that now." The student had become violent and there were no witnesses to his or Myra's behavior.

A majority of clinical faculty in the current study allowed the perpetrators of incivility to remain on the clinical unit, but later regretted their decision. No reasons were provided as to why they chose to allow them to stay. Rose described her regret of how she managed an unprofessional nursing student who did not respond to her guidance, "I should have refused him. . . . I should have let him go, called his superiors and told them he needs to be removed, because he's not working out." Likewise, Jennifer stated, "If I had to do it again, I would send her home."

When faced with incivility from nursing students, clinical faculty were surprised by the uncivil actions of their students. This finding was consistent with previous studies in which nursing students were surprised by staff nurses' incivility (Anthony & Yastik, 2011; Martel, 2015; Thomas, 2015; Walrafen et al., 2012). Reflecting on their encounters led faculty to discover how they: a) participated in the uncivil event, b) incited students to respond uncivilly out of frustration, and c) created pressure for students in the course of providing patient care. Their reactions to students' incivility

were something clinical faculty regretted but noted what they would do differently. Alaina described her reflections when she stated:

> I replay the interactions if I handle things appropriately, how differently could I speak to be more kind and give the student more grace to complete the task without feeling pressure from me, unwarranted pressures to complete the task, so I replay those again and again in my mind.

Similarly, Charlotte had reflected on an encounter with one of her students in which both of them argued with one another and shared what she learned:

> In reflecting back at the time, I realized I probably should have handled it better instead of going back and forth with her. . . . I probably should have cut if off sooner. . . . I reflected back on it soon afterwards and thought, 'You know, I should have never engaged in that conversation. I should have just said, 'This is what you were told,' and ended the conversation. . . . I could have opened it up and said, 'Tell me about,' or, 'I see that you didn't do this,' and let her explain it to me.

Reflecting helped these registered nurses to recognize certain aspects about their different encounters and what they learned from their experiences. Myra related, "Just having had time to reflect on it. . . . I recognize that he was just . . . mad at me, he was just mad at the world. He's not the type of person to take responsibility." Melanie recognized how her encounter with an uncivil nursing student during his clinical education affected her: "I remember after that incident I had to continue to remind myself that I didn't fail him. He failed himself." There are times when students will respond with incivility despite the care faculty take in providing sensitive feedback (Luparell, 2004).

Subtheme: “Coming back to life.” The subtheme *coming back to life* is a collection of ways participants recovered from their encounters with incivility. Most registered nurses learned to maintain civility in the midst of uncivil encounters and not become a part of uncivil situations. Some described the personal growth they achieved from their experiences. These findings are supported by the reflection-in-practice theory Schön (1983). If one does not learn from practice, no change will occur, perpetuating the problem, resulting in stagnant nursing practice (Powell, 1989).

Experiencing incivility from nursing students caused negative reactions in clinical faculty. Most discussed wanting to avoid situations where incivility could be directed at them. An underlying theme of incivility revealed from the narrative in this study was: Where incivility is present, people would rather be absent. In a study of resilience to social bullying, Wieland and Beitz (2015) found faculty used physical and psychological strategies to cope with being bullied, including confronting the perpetrator and avoidance through personal, physical, and psychological means. Hope described her response to a group of uncivil nursing students during post conference, “I tried to hurry through going through the rest of the rubric, and then just ending post conference there. I wanted to leave.”

After her experience with incivility Myra said, “I became mean afterward. . . . I had no intentions of coming back after my maternity leave, but I had to.” She described this period as “a very dark time in my life.” Myra admitted, “A good three years I was just going through the motions.” Her behavior demonstrated resiliency to her

encounter with student incivility in that she was attempting to avoid current nursing students. Career change was another resiliency strategy presented by Wieland and Beitz (2015), but this was not a realistic option for Myra.

Experiencing excessive incivility from staff nurses, nurse faculty, and nursing students can perpetuate incivility. Nurses can get caught up in the drama of disruptive behaviors and use this as an excuse for engaging in the same way (Walrafen et al., 2012); however, Melanie provided valuable insight into preventing this perpetuation of incivility when she stated:

> It all comes out eventually, and you just need to rise above it and try to move past it and not become part of that incivility; because eventually, if you play into it, then you become a part of it. . . . If you just move on, that's going to just eventually go away, and people really will get to see their true colors.

Her reaction demonstrates what the conceptual model of Clark and colleagues (2011) presented: well-managed stress and civility can lead to a culture of civility. Interestingly, after time had passed, some of the people who had mistreated Melanie came to her to express the respect they had for her. She explained why she believes this happened: "Because I was kind-hearted, because I was treated poorly but I still was able to back up and dust my knees off and just continue on."

Moving forward from encounters with incivility can be difficult, particularly if the perpetrator is not held accountable or if the encounter is not immediately addressed by those in authority (Walrath et al., 2010; Wieland & Beitz, 2015). Continued use of resilience strategies can help targets of incivility cope until a time for physical and

mental healing can begin (Wieland & Beitz, 2015). Myra struggled to move forward from her uncivil encounter because she also had to deal with the legal aspects of her situation for months afterward. Myra "started to come back to life" when she had a classroom of encouraging students, "I had a class I connected with, some people made me feel I brought something to the table." Having this moment allowed Myra to finally move forward. Rediscovering satisfaction in teaching and rebuilding one's professional identity can build confidence in faculty who are *coming back to life* from an uncivil encounter (Wieland & Beitz, 2015).

As discussed in the subtheme *"reflecting,"* reflection creates new knowledge from past experiences that can create change for the future. Myra's reflection was discussed in the previous subtheme. She described how her uncivil event changed her, "I feel like I've grown a lot in my own emotional maturity and the way that I handle situations." Negative patterns are well-entrenched in the nursing profession. Effective strategies are needed to combat this progressive trend (Magnavita & Heponiemi, 2011). Taking time to reflect on uncivil experiences not only helps individuals to recognize what they have learned but can decrease the shame and self-blame that can result from these types of encounters (Wieland & Beitz, 2015).

Summary

This chapter provided detailed findings of registered nurses' encounters with incivility occurring during the clinical education of nursing students. Also included was a discussion of the data management and analysis process which described the methods

used for manual coding, thematic analysis, and statement identification. A descriptive phenomenological approach guided data analysis and the identification of common themes and subtheme from the interview sessions. The findings that resulted from this process are important for stakeholders of nursing education to help improve the clinical education and work environments of nurses, increase nursing students' learning, and improved patient care and safety.

CHAPTER 5

DATA SYNTHESIS, CONCLUSIONS, RECOMMENDATIONS

This chapter presents a synthesis of the findings and conclusions of this study. The significance of this study is discussed. Implications and recommendations for nursing education, nursing practice, administration, and future research are outlined. The chapter concludes with my final thoughts about this qualitative dissertation study.

Data Synthesis

The purpose of this qualitative study was to explore registered nurses' experiences with incivility during the clinical education of nursing students within hospital settings. Descriptive phenomenology was used to allow both staff nurses and clinical faculty to answer the research question: What experiences with incivility have registered nurses encountered during the clinical education of nursing students within hospital settings? The descriptive accounts revealed contributing factors to uncivil actions, nurses' perceptions of incivility, and strategies used to either prevent or disengage from their encounters with incivility. Three themes identified from these rich descriptions included *influences on uncivil actions, describing and responding to incivility,* and *aftermath of incivility.*

Registered nurses experienced incivility either directly or indirectly by witnessing others' encounters with incivility. Mostly clinical faculty were targeted with incivility. This finding may be attributed to sample bias as the sample (*n* = 13) contained mostly clinical faculty (*n* = 8). Nursing students were found to perpetrate the most incivility as 11 encounters with students were described, however, this could be attributed to the study's focus and interview questions used. Nonetheless, nursing students are under a lot of stress during clinical education and may lack stress management and conflict resolution skills (Clark et al., 2011).

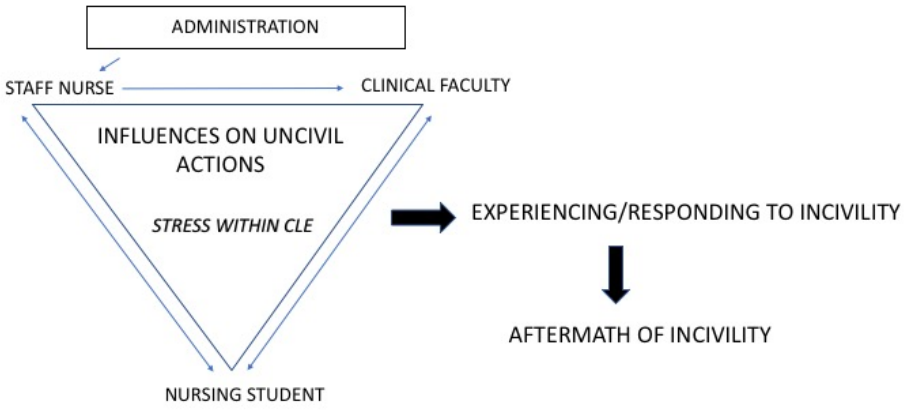


Figure 1. Conceptual model for experiences of incivility within clinical learning environments for nursing education

The phenomenon of incivility within the clinical education of nursing students is depicted in *Figure 1*. The arrows around the triangle indicate the direction of incivility

among administrators, staff nurses, clinical faculty, and nursing students as described in this study. Most notable is no participant described incivility from clinical faculty members. Incivility between nursing students and staff nurses centered around students' arrival to the clinical unit, provisions of patient care, and administration of medication. Incivility between nursing students' and clinical faculty resulted from students' feelings and perceptions of entitlement and the evaluation of clinical performance as Luparell (2011) also reported. Incivility spiked between staff nurses and clinical faculty due to unavailable faculty, thus, leaving the students to ask nurses a lot of questions. Both staff nurses and clinical faculty witnessed other staff nurses being uncivil toward students. Nursing students witnessed nurse administrator incivility toward staff nurses stemming from lack of resources on nursing unit.

Influences of incivility derived mostly from external factors; however, intrinsic incivility, considered outliers by participants in this study, also contributed to incivility. This may be attributed to individuals' lack of stress management or coping skills, particularly in nursing students. Stress was an underlying thread of uncivil encounters described in this study and others, affecting relationships between nursing students, staff nurses, and clinical faculty (Birx & Baldwin, 2002; Clark, 2008b; Clark et al., 2011; Luparell, 2004). Several organizational factors were found to be major contributors to both incivility in clinical education environments and hostility in nurses' work environments. Nurses experiencing organizational stress stemming from inadequate staffing, high patient acuity, and difficult workloads considered having a nursing student

assigned to work with them as an additional stressor. Compounding these problems were nurses' perceptions of a lack of administrative support which is a common occurrence that needs to be addressed (Aul, 2017; Clark, Olender, Kenski, & Cardoni, 2013; Luparell, 2003).

Registered nurses felt unsupported by administrators in different ways. Lack of administrative support was perceived when clinical faculty decisions regarding students and evaluations were not upheld. Staff nurses felt unsupported when colleagues' violation of behavioral codes of conduct and established policies and procedures were inconsequential. Nurses explained the main reason employees who exhibited unprofessional or uncivil behaviors were not reprimanded was because of a shortage of nurses. Unaccountability of uncivil coworkers influenced uncivil actions because nurses lacked the desire to work with their undisciplined colleagues, thus, causing reduced teamwork. The nursing shortage should not be used as an excuse by administrators to avoid administering consequences for uncivil behavior perpetrated by registered nurses. It costs thousands of dollars to replace one nurse, but more importantly, the wisdom of experienced nurses *cannot* be easily replaced (Robert Wood Johnson Foundation [RWJF], 2006). It is more beneficial for healthcare organizations to hold perpetrators of incivility accountable; doing so not only provides financial benefit, but also retains experienced nurses who understand the organization's function to prepare new nurses for practice, ultimately benefiting patients (RWJF, 2006).

Incivility, perceived as disrespectful and unprofessional behaviors, negatively affected communication and teamwork and caused physical and psychological consequences as found in previous studies (Luparell, 2004; Nicholson et al., 2014; Thomas & Burk, 2009). Uncivil behaviors were categorized as verbal, physical, and attitudinal, which included different types of disrespectful, unprofessional attitudes. These findings were similar to uncivil behaviors described in previous studies of incivility, horizontal violence, and vertical violence (Anthony & Yastik, 2011; Martel, 2015; Thomas et al., 2015; Thomas & Burk, 2009; Walrafen et al., 2012). Verbal behaviors included harsh or direct tone of voice, accusing, arguing, and inappropriate words. Physical behaviors included eye rolling, finger pointing, head bobbing, unprofessional appearance, and inappropriate cell phone use. Attitudes included uncaring, selfish, rude, defensive, entitled, superiority ("greater than thou"), and "chip on his shoulder."

Almost all registered nurses in this study were surprised by their uncivil encounters and described witnesses to incivility as "shocked," as also found in prior studies (Anthony & Yastik, 2011; Martel, 2015; Walrafen et al., 2012). Nurses were surprised by the level of disrespect demonstrated by the perpetrators and also saddened by the pervasive presence of this uncaring behavior in a caring profession. Nurses described incivility as having the tendency to escalate so quickly that one may not notice incivility until it is before him or her. Sadly, for nurses on medical-surgical units, incivility happened so frequently it went unnoticed.

Some staff nurses and clinical faculty described their own incivility which was influenced by stress and student evaluations, respectively. Staff nurses described their incivility as withholding help they knew nursing students or their faculty needed and using a direct or angry tone of voice. Clinical faculty described their incivility as pressuring students to complete tasks in a timely manner while using a stern tone of voice and arguing with students.

Experiencing incivility was shown to raise nurses' awareness of their own personal behaviors and attitudes. It also made some nurses protective of others vulnerable to being targets of incivility. For example, staff nurses who had experienced or witnessed incivility as a nursing student or witnessed it on nursing units considered nursing students on their nursing units vulnerable to incivility from other staff nurses. Therefore, nurses in this study expressed the need to protect students from uncivil nurses with the mindset that students would continue to desire completing their nursing education to the nursing profession.

Unfortunately, not all nursing students or registered nurses can be protected from incivility during clinical education. Uncivil experiences leave scars, which caused targets of incivility to become guarded toward individuals occupying the roles once inhabited by perpetrators of incivility. For example, clinical faculty who had experienced incivility from nursing students were more guarded in their interactions with future students. Nursing students who had experienced incivility from staff nurses had facial expressions indicating their dread of approaching staff nurses to initiate

contact regarding patient care. Therefore, a few staff nurses learned to watch for these signs of anxiety and stress as a way to help students acclimate to their learning environment without incivility taking place. Incivility keeps people from interacting. As revealed from the narratives, uncivil people were avoided whenever possible.

This study found nurses in any role can experience incivility. A hierarchical tendency was discovered which led people in positions of authority (staff nurses, administrators) to treat the less powerful (nursing students, staff nurses) with incivility. However, faculty experienced incivility from nursing students, most frequently when either providing feedback to or evaluating nursing students' clinical performance. Uncivil encounters were also influenced by student entitlement. Examples of student entitlement from my study included: students displeased by their clinical assignments and blatant disregard for established policies, particularly regarding inappropriate use of personal technology. Faculty experienced incivility from staff nurses most frequently as a result of being unavailable to students.

Staff nurses experienced incivility from nursing students as well as other staff nurses, nurse managers, and house supervisors. Incivility from nursing students was influenced by the type of nursing degrees held by staff nurses compared to the type of nursing education program within which students were enrolled. Staff nurses, serving as preceptors for nursing students, found students' prioritization of using personal

technology over learning from patient care as disrespectful to both the nurse and the patient. Incivility from clinical faculty was not prevalent in the experiences of these participants.

Findings from my study were well-supported by the conceptual framework utilizing Clark and colleagues' (2011) conceptual model for fostering civility in nursing education, as adapted for nursing practice, and Schön's (1983) reflection-in-action theory. Findings were mostly congruent with the contributing factors to stress within nursing education and nursing practice as outlined in the model by Clark and her colleagues (2011). This study did not find faculty superiority or technology overload as contributory to stress in nursing education. A possible explanation could be due to sample bias because a majority of the sample were clinical faculty. These participants did not admit to perceptions of superiority over their students, instead, they expressed they were not better than anyone else. Technology overload was not described in this study; however, nursing students' inappropriate use of personal technology did create stress for preceptors and clinical faculty who were evaluating these students. This study demonstrated how well-managed incivility led to a culture of civility and how poorly-managed incivility led to a culture of incivility. It was noteworthy that the majority of experiences with incivility were poorly managed, leading to the persistence of incivility.

How incivility was managed seemed to vary according to whether individuals had previously experienced or witnessed incivility in their past. Participants with no past experience had no tacit knowledge about incivility from which to draw possible

solutions to the uncivil encounters. However, participants who had reflected on their encounters with incivility were able to describe what they had learned about incivility and how they would manage similar experiences differently.

Significance of the Study

Studies of staff nurses and clinical faculty experiences with incivility during the clinical education of nursing students in hospital settings have not been reported. The reported findings in this study have addressed significant gaps in the literature and have contributed to a greater understanding of these areas. This study contributes additional knowledge of incivility from the experts on the frontlines of patient care: staff nurses and clinical faculty. The majority of studies on incivility in this study's context were mostly from perspectives of nursing students and nurse leaders' perspectives. The findings from nurses' firsthand accounts of incivility are an important contribution to overcoming incivility in the nursing profession.

The work environment of nurses in hospital settings influences the clinical education of nursing students. *Nurses eating their young,* a phrase associated within nursing practice referring to incivility from experienced nurses toward less experienced nurses since the last century, was spoken by participants in this study. Nurses perpetrating incivility are inconsistent with professional standards and are at increased risk for litigation (Wyatt, 2013). Nurses who are overwhelmed by increased workloads from inadequate staffing, lacking equipment to adequately perform patient care are likely to be uncivil toward others due to the stress of these work environments. Adding

students to this setting causes highly-stressed nurses to view students as “just one more thing” to their time-pressured shifts, increasing the risk for students to become targets of incivility.

Despite federal policies (Joint Commission, 2008, 2017) to address this phenomenon, incivility persists throughout healthcare organizations. This study identified that established behavioral policies are ineffective without consequences. However, nurses perceived administrators did not follow through on policy violations due to a national nurse shortage. Ironically, the persisting incivility resulting from lack of follow through decreases nurse retention due to the hostile environments it creates.

This study highlights the key roles administrators of both educational institutions and healthcare organizations play regarding incivility in clinical education. The behavior of members of administrations affects the entire organization. This study found administrators were mostly unengaged with their employees and were perceived to work separately from the nursing units they managed. Some administrators were uncivil toward staff nurses. For uncivil cultures in healthcare organizations and educational institutions to change, top administrators must intentionally set forth multiple changes to correct the confounding issues brought about by the multifaceted problem of incivility (Institute of Medicine, 2004).

Nursing education plays a significant role in decreasing incivility within clinical education settings. Education about identifying uncivil behaviors and how to manage uncivil encounters should be provided to nursing students, preceptors, staff nurses,

administrators, and clinical faculty who are a part of learning environments within hospital settings. The findings from this study highlight the need for nurse educators to prepare incoming nursing students to address incivility and other disruptive behaviors prior to their first clinical day and throughout their nursing curriculum. Multiple strategies were offered by participants and have been found throughout the literature, including case studies, cognitive rehearsal, and simulation (Clark et al., 2013; Hutcheson & Lux, 2011; Jenkins et al., 2013; Thomas & Burk, 2009).

Implications and Recommendations for Nursing Education

Incivility from nursing students, clinical faculty, and staff nurses occurs during clinical education in hospital settings. Academic leaders and nurse faculty have important responsibilities for ensuring nursing students are competent to enter nursing practice as safe and professional nurses. However, in order to apply theory to practice, students must enter nurses' work environments which have the potential to be hostile and unwelcoming to students. To prevent surprising staff nurses with nursing students on their clinical days, clinical faculty can ensure unit managers or charge nurses know when students will arrive.

The need for education about incivility and how to respond was a significant finding in this study and has been discussed in previous studies and reports (Anthony & Yastik, 2011; Hunt & Marini, 2011; Luparell, 2011; Thomas & Burk, 2009). Case studies and simulations were suggested teaching strategies for nurse educators to employ to

prepare nursing students for potential encounters with incivility in clinical education settings. Future research should include evaluating the effectiveness of these and other teaching strategies on the development of professional behaviors and the management of incivility. Additional research should also evaluate if this learning significantly translates to clinical education environments.

It is an unfortunate reality that nursing students will likely encounter incivility within clinical education during their nursing education journey. As recommended by nurses in this study, incivility education should be a part of clinical orientation, preparing students to recognize incivility and how to respond to uncivil encounters prior to their first clinical day (Clark, Ahten, & Macy, 2013). Additionally, students need to enhance conflict resolution skills as preparation for nursing practice (Clark et al., 2011). Incivility education should continue throughout students' nursing education curriculum and include active learning strategies such as journal clubs, case studies, or simulations (Jenkins, Kerber, & Woith, 2013). These methods provide experiential application of conflict resolution for development of tacit knowledge from which students can apply to future uncivil encounters. Additionally, educators should also explain to students how nursing units function along with students' role within these new learning environments. More importantly, nursing students should see civil and professional behaviors modeled by their nurse faculty and learn how to be civil particularly when experiencing stress (Clark et al., 2011).

Stress was an underlying thread throughout every uncivil encounter discussed in this study. Teaching students how to manage stress can decrease the risk of incivility in clinical education environments. Cognitive rehearsal and the imagination effect using mental rehearsal can reduce students' stress by making recall of theoretical knowledge easier during the performance of patient care (Griffin & Clark, 2014; Ignacio, Scherpbier, Dolmans, Rethans, & Liaw, 2017).

Generational differences between nurse faculty and nursing students create incongruences regarding acceptable professional behaviors. Professional and ethical behaviors should be clearly delineated for new nursing students in the beginning of their nursing education programs. Prior to entering clinical education environments, expectations of satisfactory clinical performance should be clearly defined.

In my study, the majority of nursing students with whom clinical faculty experienced incivility ultimately graduated and became practicing nurses. The majority of staff nurses who were uncivil toward nursing students or exhibited other unprofessional behaviors were not held accountable for their behaviors. This explains why incivility continues to persist in nursing education and nursing practice. This is incongruent with the *Code of Ethics for Nurses* which places the maintenance of healthy work environments on nurses (ANA, 2015a).

Implications and Recommendations for Nursing Practice

Nurses experience overwhelming amounts of stress in hospital work environments, negatively affecting patient care and student learning from the incivility

created from latent environmental factors. Multiple strategies are needed to address this multi-faceted issue. First, education regarding stress management should be a part of nurses' continuing education followed by learning to identify uncivil behaviors and how to respond to uncivil encounters. Second, nurses need to report incivility and cite the contributing factors. In addition, nurses should be a part of organizational committees charged with developing and revising behavioral policies affecting nurses' work environments (ANA, 2015a).

In my study, the lack of registered nurses' knowledge of hospital policies and procedures regarding incivility and other disruptive behaviors was astonishing. Education about incivility in hospital settings is lacking. Main teaching points about incivility should include how to identify uncivil behaviors, how to respond appropriately, and the importance of being consistent with holding perpetrators accountable. This education should emphasize the negative effects of incivility on patient safety and clinical education as well as organizations' financial cost resulting from the nurse turnover that may occur after uncivil actions. Further, administrators, staff nurses, and preceptors should be offered continuing education annually to ensure they are able to identify incivility and respond to each encounter appropriately.

An unsettling confirmation from this study was nurses eat their young. Nursing students frequently feel unwelcomed on nursing units and do not always understand how the units function. Despite the effect of hostile work environments, the wisdom of experienced nurses is needed to educate and encourage the next generation of nurses

(Birks, Budden, Biedermann, Park, & Chapman, 2018; RWJF, 2006). To create welcoming environments for nursing students, invitational theory and Watson's theory of caring can be used by hospital staff as a framework for developing inviting and caring clinical education environments where nursing students' learning can flourish.

Nurses were unaware of established behavioral policies and procedures healthcare organizations. Registered nurses throughout healthcare organizations could conduct quality improvement projects to determine educational needs of employees regarding behavioral policies. Research indicates employees of healthcare organizations should be educated regularly regarding incivility and other disruptive behaviors (RWJF, 2006).

Implications and Recommendations for Administration

Incivility is perceived to be worsening within healthcare organizations. This could be attributed to national changes in healthcare management affecting financial resources and organizational systems. Therefore, registered nurses need the support of hospital administrators now more than ever to positively affect organizational cultures, adequate staffing and supplies, work processes, and management.

Reason's (2000) Swiss cheese model of system accidents helps illustrate how incivility in hospital settings leads to adverse events. Most of the contributing factors to incivility found in this study are what Reason (2000) referred to as latent conditions: the unnoticed weaknesses in a system that become realized once an active failure has occurred. The contributing factors to incivility (i.e., lack of adequate staffing and

supplies) found in this study are latent conditions. These contribute to the active failure of incivility. The active failure of incivility results in distracted nurses who are not as attentive to patients' signs and symptoms or missed learning opportunities for students. Active failures cause adverse events like patient harm or nursing student attrition. Based on the IOM report from 2004, healthcare organizations with problems like these need a broad transformation to address latent conditions that contribute to incivility. This transformation requires implementing multiple strategies targeted to key areas such as the workforce and organizational culture.

Some significant contributing factors to incivility found in this study were beyond the control of registered nurses. These factors were perceived as a lack of support from administration, unaccountability for violation of behavioral policies, and a lack of resources. It is paramount for administrators to lead the way in fostering civility within their organizations in order to create a civil culture within nursing practice and the nursing profession. Hospital administrators are empowered to provide adequate resources and support for practicing nurses.

This study found nurses are not held accountable for unprofessional behaviors, such as frequent "call-ins." Even worse, staff nurses who perpetrated incivility were either not reprimanded immediately or not held accountable for their actions at all. Most healthcare facilities have had zero tolerance policies in place since the Joint Commission's sentinel event alert went into effect in 2009. However, hospital

administrators have to hold perpetrators of incivility accountable as soon as the event occurs for these policies to effectively combat incivility. Additionally, administrators of both educational institutions and healthcare facilities need to ensure all staff members are educated about incivility, particularly before entering practice environments at higher risk for incivility, such as medical-surgical units.

Civil collaboration is essential to creating and maintaining civil work environments, subsequently leading to civil clinical educations environments where students' learning can flourish. Administrators and managers must show they value their staff. They must also intentionally create civil cultures as mandated by the Joint Commission in 2017. Schön's (1983) theory explains how organizations perpetuate an uncivil culture when contextual factors that contribute to stress are not addressed or when uncivil workers are not held accountable. The context within which practitioners' actions are performed can shape the perspective of their individual practice. These actions become intuitive within various contexts (Schön, 1983).

Recommendations for Future Research

The nursing profession will benefit from further research on the unexpected contributing factors to incivility such as gender, generational differences, and perceptions of types of nursing degrees within direct patient care environments. Although there was only one male participant, it may be that males do not perceive behaviors deemed uncivil by female nurses as incivility. Generational differences of perceptions of disrespectful

behaviors were discovered. Likewise, it is possible that perceptions of incivility within hospital settings vary according to regions within the United States, warranting additional investigation.

The majority of nursing students described in this study were in the latter part of their nursing education. Future studies need to evaluate the cause of incivility from these more experienced nursing students. It is important to determine if students learned these behaviors as a result of experiencing incivility themselves or if they are a result from the stress and possible burnout associated with being a nursing student. Determining the sources of potential experiences with incivility is crucial as well as emphasizing consistent use of coping mechanisms.

Findings indicate incivility in the learning environments of nursing students continues to abound despite the growing number of regulations and strategies put forth by researchers, professional organizations, and regulating bodies to address it (ANA, 2015a; Clark et al., 2011; Cronenwett et al., 2007; Joint Commission, 2008; Wyatt, 2016). It is possible healthcare organizations have not fully adopted recommendations from the Joint Commission and other entities. If strategies have been implemented, research should be done to discover why they are ineffective. Leaders should start with an assessment of their organizations to identify stressors and determine interventions to address organizational culture and modifiable stressors (National Institute for Occupational Safety and Health [NIOSH], 2014). A forum for interprofessional

collaboration, including expert nurses, should discuss possible solutions and ensure ongoing studies to determine the effectiveness of the interventions (NIOSH, 2014).

This study was limited by the lack of gender diversity in this sample. Future studies of incivility need a fair representation of males to better understand incivility in clinical education. Another limitation was the small sample size from the southeastern United States. These findings may not be generalizable to other populations. Future studies should compare incivility across regions in the United States and globally. A third limitation was all members of the sample had educational experience with nursing students. This likely happened because I purposefully sought registered nurses with at least two years of experience as a nurse in an attempt to control for stress related to a new career. Experienced nurses are usually selected for mentorship and preceptorship. Future studies need to explore incivility in clinical education with registered nurses who have not educated nursing students in order to gain a different perspective about this phenomenon.

There were three unexpected findings from this study. The first unexpected finding was the difference in perceptions of incivility among males and females. Although there was only one male participant, it may be that males do not perceive behaviors deemed uncivil by female nurses as incivility. This could be affected by males' focus on patient care or their having different coping skills that moderate their response to stress in the work environment. This warrants further exploration as no studies were found regarding gender differences in perceptions of incivility.

A second unexpected finding was the impact different types of nursing programs and nursing degrees had on incivility. Nursing students enrolled in BSN programs perceived their roles regarding hands-on patient care differently than the BSN-prepared staff nurses who were assigned to their patients. Staff nurses perceived nursing students differently based on the nursing schools to which they were affiliated. These nurses expected problems from students enrolled in certain schools compared to others but did not identify them according to degrees offered. Further research is needed regarding the influence of nursing degree types on incivility as no published studies could be found.

A third unexpected finding was the lack of both clinical faculty and staff nurses' knowledge regarding hospital policies and procedures for disruptive behaviors. One explanation for their lack of knowledge was not having to refer to behavioral policies during their shift. Although not familiar with hospital behavioral policies, clinical faculty were very knowledgeable about behavioral policies of their educational institutions, likely as a result of their primary role of student evaluation. Most research suggests nurses should consult organizational policies and procedures to know how to address an uncivil encounter. However, the participants in this study had experienced incivility and were unaware of their organizations' behavioral polices. This finding indicates a significant need for educating hospital employees about identifying incivility and the associated policies. This education should be extended to clinical faculty and nursing students prior to arriving to these hospitals for clinical education.

Final Reflections

This research supports what the nursing literature has indicated since the 20th century: Incivility exists in nursing practice and nursing education, negatively affecting registered nurses, nurse education, nursing students, and patients. Incivility is disrespectful and unprofessional behaviors caused by stress that disrupt communication, collaboration, and teamwork. Where incivility is present, people would rather be absent; this includes nursing education and the nursing profession. If people would rather not be in a place where incivility is present, then collaboration, teamwork, effective communication, civil interactions, and effective learning cannot occur.

The findings presented from this study are a sad and concerning reminder of the sluggish manner in which changes in the nursing profession are occurring. For decades, staff nurses have voiced concerns about the stressors of high patient acuity mixed with low staffing levels. Registered nurses are expert professionals who should have a strong voice in communication with administrators and policy makers. Their suggestions should not be taken lightly as they are the ones who possess the knowledge of what is best for patient care. Something has got to give in the balance administrators try to maintain between pleasing third party payors and maintaining adequate staff and equipment. Administrators must find innovative ways to maintain patient safety as their primary focus. Payors and regulating bodies must be willing to make adjustments to prevent administrators from having to make difficult decisions that usually result in removing resources from the patient care environment. As this study and many others

have shown, civil work environments positively affect patient safety, quality of patient care, employee satisfaction, and reduced turnover. Hospital administrators have no choice but to take action for ensuring these factors are consistently maintained.

Summary

This chapter presented a synthesis of my study's findings and explained the study's significance. Implications and recommendations for nursing education, nursing practice, and administrators were delineated. The chapter concluded with recommendations for future research and my final reflections.

The conceptual framework provided by Clark and colleagues (2011) and Schön (1983) was robust enough to support the entire research process as well as the findings in this study. The valuable contributions of registered nurses to this study evidence the danger of incivility to the well-being of those directly involved in uncivil encounters as well as the bystanders who are indirectly affected, including hospitalized patients and witnesses to incivility. Rich descriptions of registered nurses' experiences with incivility have highlighted the multiple influences on uncivil actions and how registered nurses responded to encounters of incivility. Effective strategies used to mitigate this dangerous phenomenon were also revealed. Highly evident is the need for all professionals, staff, and students to be educated about what incivility is, how to notice it, and how to respond. The rich descriptions presented in this study can help

stakeholders associated with nursing education gain a better understanding of this phenomenon to better prepare future nursing students, professional nurses, and clinical faculty.

REFERENCES

Academy of Medical-Surgical Nurses. (n.d.). *Healthy work environment advocacy guide: Workplace bullying and lateral violence among nurses.* Retrieved from https://www.amsn.org/sites/default/files/documents/practice-resources/healthy-work-environment/AMSN-HWE-Bullying.pdf

Academy of Medical-Surgical Nurses. (2012). *Scope and standards of medical-surgical nursing practice*. Retrieved from https://www.amsn.org/sites/default/files/documents/practice-resources/scope-and-standards/AMSN-Scope-Standards-MS-Nursing.pdf

Altmiller, G. (2012). The role of constructive feedback in patient safety and continuous quality improvement. *Nursing Clinics of North America, 47,* 365-374. http://dx.doi.org/10.1016/j.cnur.2012.05.002

Amann, A., & Williams, A. M. (1960). Staff-student relationship in a public health agency. *Nursing Outlook, 9,* 318-319.

American Association of Colleges of Nursing. (2017). *Fact sheet: Nursing shortage.* Retrieved from http://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet-2017.pdf

American Association of Critical Care Nurses. (2016). *AACN's standards for establishing and sustaining healthy work environments*. Retrieved from http://www.aacn.org/wd/hwe/docs/hwestandards.pdf

American Nurses Association. (2006). *Workplace abuse and harassment of nurses*. (Summary of Proceedings, Resolutions: Workplace Abuse). Retrieved from http://nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/WorkplaceAbuseandHarassmentofNurses-1.pdf

American Nurses Association. (2014). *Healthy work environment*. Retrieved from http://nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment

American Nurses Association. (2015a). *Code of ethics for nurses with interpretive statements*. Washington, DC: Author.

American Nurses Association. (2015b). *Incivility, bullying and workplace violence.* [Position statement]. http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Nurse/bullyingworkplaceviolence/Incivility-Bullying-and-Workplace-Violence.html

Anthony, M., & Yastik, J. (2011). Nursing students' experiences with incivility in clinical education. *Journal of Nursing Education, 50*, 140-144. doi:10.3928/01484834-20110131-04

Anthony, M., Yastik, J., MacDonald, D. A., & Marshall, K. A. (2014). Development and validation of a tool to measure incivility in clinical nursing education. *Journal of Professional Nursing*, 30, 48-55 http://dx.doi.org/10.1016/j.profnurs.2012.12.011

Aul, K. (2017). Who's uncivil to who? Perceptions of incivility in pre-licensure nursing programs. *Nurse Education in Practice*, 27, 2736-2744. doi:10.1016/j.nepr.2017.08.016

Babenko-Mould, Y., & Laschinger, H. S. (2014). Effects of incivility in clinical practice settings on nursing student burnout. *International Journal of Nursing Education Scholarship, 11,* 145-154. doi:10.1515/ijnes-2014-0023

Becher, J., & Visovsky, C. (2012). Horizontal violence in nursing. *Medsurg Nursing, 21,* 210-232.

Beckmann, C. A., & Cannella, B. L. (2015). Factors related to intimidation during oxytocin administration. *Journal of Perinatal & Neonatal Nursing, 29*, 305-314. doi:10.1097/JPN.0000000000000134

Birks, M., Budden, L. M., Biedermann, N., Park, T., & Chapman, Y. (2018). A 'rite of passage?': Bullying experiences of nursing students in Australia. *Collegian, 25*, 45-50. https://doi.org/10.1016/j.colegn.2017.03.005

Birx, E., & Baldwin, S. (2002). Nurturing staff-student relationships. *Journal of Nursing Education, 41*, 86-88.

Bureau of Labor Statistics, U.S. Department of Labor. (2018). *Occupational employment statistics: Occupational employment and wages, May 2017.* Retrieved from http://www.bls.gov/oes/current/oes291141.htm

Bureau of Labor Statistics, U.S. Department of Labor. (2016). *Occupational outlook handbook, 2016-17 Edition*, *Registered Nurses*, Retrieved from http://www.bls.gov/ooh/Healthcare/Registered-nurses.htm#tab-3

Center for American Nurses. (2008). Lateral violence and bullying in the workplace [Position statement]. Retrieved from https://www.mc.vanderbilt.edu/root/pdfs/nursing/center_lateral_violence_and_bullying_position_statement_from_center_for_american_nurses.pdf

Clark, C. (2008a). Student voices on faculty incivility in nursing education: A conceptual model. *Nursing Education Perspectives*, *29*, 284-289.

Clark, C. (2008b). The dance of incivility in nursing education as described by nursing faculty and students. *Advances in Nursing Science, 31*, E37-54.

Clark, C. M., Ahten, S. M., & Macy, R. (2014). Nursing graduates' ability to address incivility: Kirkpatrick's level-3 evaluation. *Clinical Simulation in Nursing*, *10*, 425-431. doi:10.1016/j.ecns.2014.04.005

Clark, C. M., & Carnosso, J. (2008). Civility: A concept analysis. *Journal of Theory Construction and Testing, 12*, 11-15.

Clark, C. M., Farnsworth, J., & Landrum, R. E. (2009). Development and description of the incivility in nursing education survey. *Journal of Theory Construction and Testing, 13*, 1-15.

Clark, C. M., Olender, L., Cardoni, C., & Kenski, D. (2011). Fostering civility in nursing education and practice. *Journal of Nursing Administration, 41*, 324-333. http://dx.doi.org.proxy-s.mercer.edu/10.1097/NNA.0b013e31822509c4

Clark, C. M., Olender, L., Kenski, D., & Cardoni, C. (2013). Exploring and addressing faculty-to-faculty incivility: A national perspective and literature review. *Journal of Nursing Education*, *52*, 211-218. doi:10.3928/01484834-20130319-01

Clark, C. M., & Springer, P. J. (2007a). Incivility in nursing education: A descriptive study of definitions and prevalence. *Journal of Nursing Education, 46*, 7-14.

Clark, C. M., & Springer, P. J. (2007b). Thoughts on incivility: Student and faculty perceptions of uncivil behavior in nursing education. *Nursing Education Perspectives, 28*, 93-97.

Clark, C., & Springer, P. (2010). Academic nurse leaders' role in fostering a culture of civility in nursing education. *Journal of Nursing Education*, *49*, 319-325. doi:10.3928/01484834-20100224-01

Clarke, C. M., Kane, D. J., Rajacich, D. L., & Lafreniere, K. D. (2012). Bullying in undergraduate clinical nursing education. *Journal of Nursing Education, 51*, 269-276. http://dx.doi.org/10.3928/01484834-20120409-01

Coursey, J. H., Rodriguez, R. E., Dieckmann, L. S., & Austin, P. N. (2013). Successful implementation of policies addressing lateral violence. *AORN Journal, 97,* 101-109. http://dix.doi.org/10.1016/j.aorn.2012.09.010

Creswell, J. W. (1998). *Quality inquiry and research design: Choosing among 5 traditions.* Thousand Oaks, CA: Sage.

Cronenwett, L., Sherwood, G., Barnsteiner, J., Disch, J., Johnson, J., Mitchell, P., & Warrant, J. (2007). Quality and safety education for nurses*. Nursing Outlook, 55*, 122-131. doi:10.1016/j.outlook.2007.02.006

D'ambra, A. M., & Andrews, D. R. (2014). Incivility, retention and new graduate nurses: An integrated review of the literature. *Journal of Nursing Management*, *22*, 735-742. doi:10.1111/jonm.12060

Daniel, L., Adams, B., & Smith, N. (1994). Academic misconduct among nursing students: A multivariate investigation. *Journal of Professional Nursing, 10*, 278-288.

de Fulvio, B., Stichler, J. F., & Gallo, A. (2015). Teaching future nurses in the clinical setting. *Journal of Nursing Administration, 45*, 21-27. doi:10.1097/NNA.0000000000000156

Ditmer, D. (2010). A safe environment for nurses and patients: Halting horizontal violence. *Journal of Nursing Regulation, 1*(3), 9-14.

Ducharme, M. P., Bernhardt, J. M., Padula, C. A., & Adams, J. M. (2017). Leader influence, the professional practice environment, and nurse engagement in essential nursing practice. *Journal of Nursing Administration, 47,* 367-375. doi:10.1097/NNA.0000000000000497

Felblinger, D. M. (2008). Incivility and bullying in the workplace and nurses' shame responses. *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* 2, 234-241. doi:10.1111/j.1552-6909.2008.00227.x

Gallagher, S., & Zahavi, D. (2008). *The phenomenological mind: An introduction to philosophy of mind and cognitive science*. New York, NY: Routledge.

Gallus, J. A., Bunk, J. A., Matthews, R. A., Barnes-Farrell, J. L., & Magley, V. J. (2014). An eye for an eye? Exploring the relationship between workplace incivility experiences and perpetration. *Journal of Occupational Health Psychology, 19*, 143-154. doi:10.1037/a0035931

Giorgi, A. (1985). *Phenomenology and psychological research.* Pittsburgh, PA: Duquesne University.

Giorgi, A. (2008). Difficulties encountered in the application of the phenomenological method in the social sciences. *The Indo-Specific Journal of Phenomenology, 8*(1), 1-9. Retrieved from http://www.ajol.info/index.php/ipjp/article/viewFile/65428/53118

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA: Duquesne University Press.

Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *Journal of Continuing Education in Nursing*, *45*, 535-542. doi:10.3928/00220124-20141122-02

Hamblin, L. E., Essenmacher, L., Upfal, M. J., Russell, J., Luborsky, M., Ager, J., & Arnetz, J. E. (2015). Catalysts of worker-to-worker violence and incivility in hospitals. *Journal of Clinical Nursing, 24*, 2458-2467. doi:10.1111/jocn.12825

Hayhurst, A., Saylor, C., & Stuenkel, D. (2005). Work environmental factors and retention of nurses. *Journal of Nursing Care Quality*, *20*, 283-288.

Hegenbarth, M., Rawe, S., Murray, L., Arnaert, A., & Chambers-Evans, J. (2015). Establishing and maintaining the clinical learning environment for nursing students: A qualitative study. *Nurse Education Today, 35*, 304-309. doi:10.1016/j.nedt.2014.10.002

Hilbert, G. (1985). Involvement of nursing students in unethical classroom and clinical behaviors. *Journal of Professional Nursing*, *1*, 230-234.

Hunt, C., & Marini, Z. A. (2012). Incivility in the practice environment: A perspective from clinical nursing teachers. *Nurse Education in Practice, 12,* 366-370. doi:10.1016/j.nepr.2012.05.001

Husserl, E. (1931/1962). *Ideas: General introduction to pure phenomenology*. (W. R. Boyce Gibson, Trans.) New York: Collier Books.

Hutcheson, J., & Lux, K. (2011). Reader's theater: A teaching strategy to help students respond to disruptive behavior. *Journal of Nursing Education, 50,* 294-297. doi:10.3928/01484834-20110317-01

Hutchinson, M., & Jackson, D. (2015). The construction and legitimation of workplace bullying in the public sector: Insight into power dynamics and organisational *[sic]* failures in health and social care. *Nursing Inquiry, 22*, 13-26. doi:10.1111/nin.12077

Hutchinson, M., Vickers, M., Jackson, D., & Wilkes, L. (2006). Workplace bullying in nursing: Towards a more critical organizational perspective. *Nursing Inquiry, 13*, 118-126.

Ignacio, J., Scherpbier, A., Dolmans, D., Rethans, J., & Liaw, S. Y. (2017). Mental rehearsal strategy for stress management and performance in simulations. *Clinical Simulation in Nursing*, *13*, 295-302. doi:10.1016/j.ecns.2017.04.005

Institute for Safe Medication Practices. (2013, October 3). *Intimidation is still a problem in hospital workplace, ISMP survey shows* [Press release]. Retrieved from https://www.ismp.org/pressroom/PR20131003.pdf

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses*. Washington, D. C.: National Academies Press. Retrieved from: https://www.nap.edu/read/10851/chapter/1

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. [Report brief]. Retrieved from https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Report%20Brief.pdf

International Council of Nurses. (2007). *Workplace bullying in the health sector*. Retrieved from http://www.icn.ch/images/stories/documents/publications/fact_sheets/19l_FS-Bullying_Health_Sector.pdf

International Council of Nurses. (2008). *Positive practice environments for health professionals.* Retrieved from http://www.icn.ch/images/stories/documents/publications/fact_sheets/17d_FS-Positive_Practice_Environments_HC_Professionals.pdf

Jackson, J., & Neighbors, M. (1988). A study of nurses' attitudes toward associate degree nursing students. *Journal of Advanced Nursing, 13,* 405-409. http://dx.doi.org.proxy-s.mercer.edu/10.1111/j.1365-2648.1988.tb01436.x

Jamieson, J., Mitchell, R., Le Fevre, J., & Perry, A. (2015). Bullying and harassment of trainees: An unspoken emergency? *Emergency Medicine Australasia, 27*, 464-467. doi:10.1111/1742-6723.12465

Jenkins, S. D., Kerber, C. S., & Woith, W. M. (2013). An intervention to promote civility among nursing students. *Nursing Education Research, 34,* 95-100.

Joint Commission. (2008, July 9). Behaviors that undermine a culture of safety. *Sentinel Event Alert, 40*, 1-3. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_40.PDF

Joint Commission. (2017, March 1). Leadership committed to safety. *Sentinel Event Alert, 43*, 1-3. Retrieved from https://www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf

Lachman, V. D. (2014). Ethical issues in the disruptive behaviors of incivility, bullying, and lateral/violence. *MedSurg Nursing, 23,* 56-60.

Lashley, F., & De Meneses, M. (2001). Student civility in nursing programs: A national survey. *Journal of Professional Nursing*, *17*, 81-86.

Levett-Jones, T., Lathlean, J., Higgins, I., & McMillan, M. (2009). Staff-student relationships and their impact on nursing students' belongingness and learning. *Journal of Advanced Nursing, 65*, 316-324. doi:10.1111/j.13652648.2008.04865.x

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

LoBiondo-Wood, G., & Haber, J. (2010). *Nursing research: Methods and critical appraisal for evidence-based practice*. St. Louis, MO: Mosby Elsevier.

Lucian Leape Institute. (2013). *Through the eyes of the workforce: Creating joy, meaning, and safer healthcare.* Retrieved from http://www.patientcarelink.org/uploadDocs/1/Through-Eyes-of-the-Workforce_online.pdf

Luparell, S. M. (2003). *Critical incidents of incivility by nursing students: How uncivil encounters with students affect nursing faculty* (Doctoral Dissertation). Retrieved from ProQuest Dissertations & Theses Global. (Order No. 3092571).

Luparell, S. (2004). Faculty encounters with uncivil nursing students: An overview. *Journal of Professional Nursing, 20*, 59-67. doi:10.1016/j.profnurs.2003.12.007

Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. *Critical Care Nurse, 31*(2), 92-95. doi:10.4037/ccn2011171

Lux, K. M., Hutcheson, J. B., & Peden, A. R. (2014). Ending disruptive behavior: Staff nurse recommendations to nurse educators. *Nurse Education in Practice, 14*, 37-42. doi:10.1016/j.nepr.2013.06.014

Lynette, J., Echevarria, I., Sun, E., & Greene Ryan, J. (2016). Incivility across the nursing continuum. *Holistic Nursing Practice*, *30*, 263-268. doi:10.1097/HNP.0000000000000167

Magnavita, N., & Heponiemi, T. (2011). Workplace violence against nursing students and nurses: An Italian experience. *Journal of Nursing Scholarship, 43,* 203-210.

Martel, M. E. (2015). *Bachelor's degree nursing students' lived experiences of nursing staff's incivility: A phenomenological study* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses Global. (Order No. 3687637)

Matsumura, G., Callister, L., Palmer, S., Cox, A., & Larsen, L. (2004). Staff nurse perceptions of the contributions of students to clinical agencies. *Nursing Education Perspectives, 25*, 297-303.

McIntyre, R., & Smith, D. W. (1989). *Theory of intentionality.* In J. N. Mohanty and William R. McKenna (Eds.), *Husserl's phenomenology: A textbook*. Washington, D C: Center for Advanced Research in Phenomenology and University Press of America. Retrieved from http://consc.net/neh/papers/ smith2.pdf

McNally, G., Frey, R., & Crossan, M. (2017). Nurse manager and student nurse perceptions of the use of personal smartphones or tablets and the adjunct applications, as an educational tool in clinical settings. *Nurse Education in Practice*, *23,* 231-237. doi:10.1016/j.nepr.2016.12.004

Mohanty, J. N. (1989). *Transcendental phenomenology: An analytic account*. Oxford, U K: Basil Blackwell.

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Munhall, P. L. (2012). *Nursing research: A qualitative perspective.* Sudbury, MA: Jones & Bartlett Learning.

National Council of State Boards of Nursing. (2011, August). *White paper: A nurse's guide to the use of social media.* Retrieved from https://www.ncsbn.org/Social_Media.pdf

National Council of State Boards of Nursing. (2016). A changing environment: 2016 NCSBN environmental scan. *Journal of Nursing Regulation, 6*(4)*,* 4-37. http://dx.doi.org/10.1016/S2155-8256(16)31007-9

National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. (2014). *Stress . . . at work*. Retrieved from https://www.cdc.gov/niosh/docs/99-101/pdfs/99-101.pdf

National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention. (2016). *Workplace violence prevention for nurses.* Retrieved from https://wwwn.cdc.gov/wpvhc/Course.aspx/Slide/Unit1_4

National League for Nursing. (2012). *Ethical principles for nursing* education. Retrieved from http://www.nln.org/docs/default-source/default-document-library/ethical-principles-for-nursing-education-final-final-010312.pdf?sfvrsn=2

Nicholson, R. M., Leiter, M. P., & Laschinger, H. K. (2014). Predicting cynicism as a function of trust and civility: A longitudinal analysis. *Journal of Nursing Management*, *22*, 974-983. doi:10.1111/jonm.12073

Nikstaitis, T., & Coletta Simko, L. (2014). Incivility among intensive care nurses. *Dimensions of Critical Care Nursing*, *33*, 293-301. doi:10.1097/

DCC.0000000000000061

Occupational Safety and Health Administration. (2004). *Guidelines for preventing workplace violence for healthcare and social service workers.* Retrieved from https://www.osha.gov/Publications/OSHA3148/osha3148.html

Occupational Safety and Health Administration. (2015). *Guidelines for preventing workplace violence for healthcare and social service workers.* Retrieved from https://www.osha.gov/Publications/osha3148.pdf

Polanyi, M. (1966). *The tacit dimension*. Garden City, NY: DoubleDay.

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia, PA: Wolters Kluwer|Lippincott Williams & Wilkins.

Powell, J. (1989). The reflective practitioner in nursing. *Journal of Advanced Nursing*, *14*, 824-832. doi:10.1111/j.1365-2648.1989.tb01467.x

Randle, J. (2001). The effect of a 3-year pre-registration training course on students' self-esteem. *Journal of Clinical Nursing*, *10*, 293-300. doi:j.1365-2702.2001.00483.x10.1111/j.1365-2702.2001.00483.x

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43,* 395-401. doi:10.1046/j.1365-2648.2003.02728.x

Randle, J., & Stevenson, K. (2007). Reducing workplace bullying in healthcare organizations. *Nursing Standard, 21,* 49-56.

Reason, J. (2000). Human error: Models and management. *BMJ: British Medical Journal (International Edition)*, *320*, 768-770.

Robert Wood Johnson Foundation. (2006, June). *Wisdom at work: The importance of the older and experienced nurse in the workplace.* Retrieved from https://www.rwjf.org/content/dam/farm/reports/reports/2006/rwjf13773

Saldaña, J. (2011). *Fundamentals of qualitative research*. New York, NY: Oxford University Press.

Saldaña, J. (2013). *The coding manual for qualitative researchers*. Los Angeles, CA: Sage.

Schön, D. A. (1983). *The reflective practitioner: How professionals think in action,* NY: Basic Books.

Spence Laschinger, H. K. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *Journal of Nursing Administration, 44*, 284-290. doi:10.1097/NNA.0000000000000068

Stockhausen, L. (2006). Métier artistry: Revealing reflection-in-action in everyday practice. *Nurse Education Today*, *26*, 54-62.

Streubert, H. J., & Carpenter, D. R. (2011). *Qualitative research in nursing: Advancing the humanistic imperative* (5th ed.). Philadelphia, PA: Lippincott Williams & Wilkins

Suplee, P. D., Lachman, V. D., Siebert, B. S., & Anselmi, K. K. (2008). Managing nursing student incivility in the classroom, clinical setting, and on-line. *Journal of Nursing Law, 12*(2), 68-77. doi:10.1891/1073-7472.12.2.68

Tecza, B. M., Boots, B. K., Clay, P. M., Kirkman, K. S., Mains, B. C., Newton, E. E., & Bartlett, J. A. (2015). Development of an instrument to measure civil and uncivil behaviors in the hospital clinical environment. *Journal of Nursing Administration*, *45*, 391-397. doi:10.1097/NNA.0000000000000220

Thomas, C. A. (2015). *Nursing student encounters with incivility during education in a clinical setting* (Doctoral dissertation). Retrieved from ProQuest Dissertations & Theses Global. (Order No. 3682985)

Thomas, J., Jinks, A., & Jack, B. (2015). Finessing incivility: The professional socialization experiences of student nurses' first clinical placement, a grounded theory. *Nurse Education Today, 35,* e4-e9. doi:http://dx.doi.org/10.1016/j.nedt.2015.08.022

Thomas, S. P., & Burk, R. (2009). Junior nursing students' experiences of vertical violence during clinical rotations. *Nursing Outlook, 57,* 226-231. doi:10.1016/j.outlook. 2008.08.004

Tiwake, S. U., Caranto, L. C., & David, J. J. T. (2015). The real world: Lived experiences of student nurses during clinical practice. *International Journal of Nursing Science 2015, 5*(2), 66-75 doi:10.5923/j.nursing.20150502.05

Vallant, S., & Neville, S. (2006). The relationship between student nurse and nurse clinician: Impact on student learning. *Nursing Praxis in New Zealand*, *22*(3), 23-33.

van Iersel, M., Latour, C. H., de Vos, R., Kirschner, P. A., & Scholte op Reimer, W. J. (2016). Nursing students' perceptions of community care and other areas of nursing practice – A review of the literature. *International Journal of Nursing Studies, 61*, 611-619. doi:10.1016/j.ijnurstu.2016.05.011

Walrafen, N., Brewer, N. K., & Mulvenon, C. (2012). Sadly caught up in the moment: An exploration of horizontal violence. *Nursing Economic$, 30*, 13-13.

Walrath, J., Dang, D., & Nyberg, D. (2010). Hospital RNs' experiences with disruptive behavior: A qualitative study. *Journal of Nursing Care Quality*, *25*(2), 105-116. doi:10.1097/NCQ.0b013e3181c7b58e

Wieland, D., & Beitz, J. M. (2015). Resilience to social bullying in academia: A phenomenological study. *Nurse Educator, 40*, 289-293. doi:10.1097/NNE.0000000000000169

Workplace Bullying Institute. (2017, July 7). *2017 WBI U.S. survey: What stops workplace bullying?* Retrieved from http://www.workplacebullying.org/2017-stopping/

Wyatt, R. M. (2013, October 2). High reliable healthcare: Revisiting disruptive and inappropriate behavior: Five years after standards introduced. [Web blog post] Retrieved from https://www.jointcommission.org/jc_physician_blog/revisiting_disruptive_and_inappropriate_behavior/

Ziefle, K. (2018). Incivility in nursing education: Generational differences. *Teaching & Learning in Nursing, 13*(1), 27-30. doi:10.1016/j.teln.2017.09.004

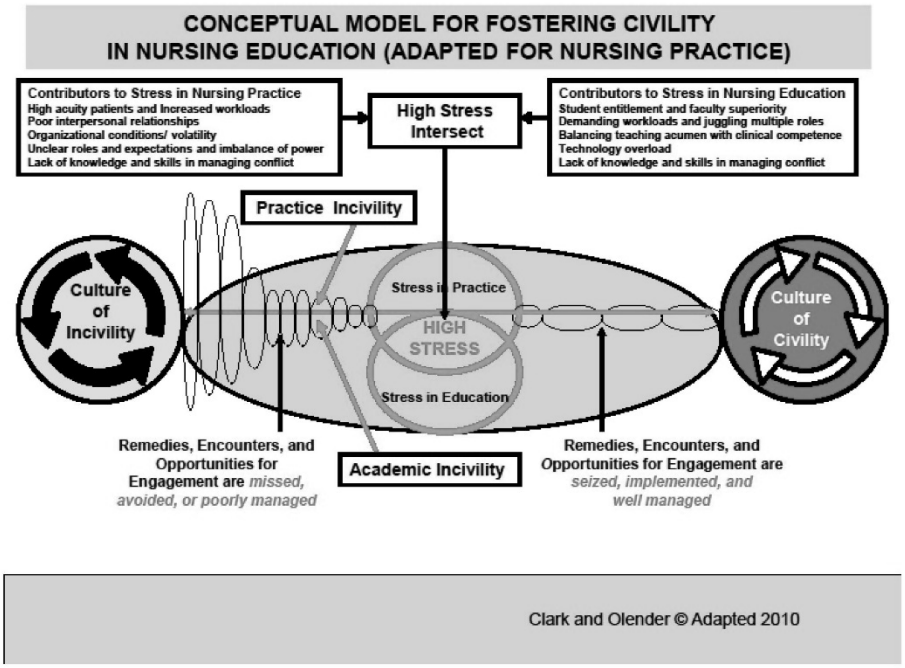
Zimmerman, T., & Amori, G. (2011). The silent organizational pathology of insidious intimidation. *Journal of Healthcare Risk Management, 30*, 5-15. doi:10.1002/jhrm.2005

APPENDICES

APPENDIX A

CONCEPTUAL MODEL FOR FOSTERING CIVILITY IN NURSING EDUCATION (ADAPTED FOR NURSING PRACTICE)

Conceptual Model to Foster Civility in Nursing Education (Adapted for Nursing Practice)



Clark, C. M., Olender, L., Cardoni, C., & Kenski, D. (2011). Fostering civility in nursing education and practice: Nurse leader perspectives. *Journal of Nursing Administration, 41*(7/8), 324-330.

APPENDIX B

INVITATIONAL FLYER

ATTENTION REGISTERED NURSES

Please share your experiences of incivility during the clinical education of nursing students.

You are invited to participate in a doctoral research study*. The purpose of this study is to understand registered nurses' perceptions and experiences of incivility during the clinical education of nursing students. Your insight into these experiences will contribute to improving nursing education, the nursing profession, and patient safety. If you choose to volunteer you will participate in a one-on-one interview session, lasting approximately 60 to 90 minutes, to describe your experiences. After the interview, you will be provided a ***$25 gift card to Target.***

Don't miss this opportunity to contribute to the voices of staff nurses on this critical issue!

Please email or call to register to ask any questions.
Kimberly M. French (Kimberly.m.french@live.mercer.edu/205-451-8770)

Doctoral research study: *Experiences of Registered Nurses Who Encounter Incivility During the Clinical Education of Nursing Students: A Phenomenological Analysis*

Participation is voluntary and confidential

APPENDIX C

INFORMED CONSENT

MERCER UNIVERSITY

Georgia Baptist College of Nursing

EXPERIENCES OF REGISTERED NURSES WHO ENCOUNTER INCIVILITY DURING THE CLINICAL EDUCATION OF NURSING STUDENTS: A PHENOMENOLOGICAL ANALYSIS

Informed Consent

You are being asked to participate in a research study. Before you give your consent to volunteer, it is important that you read the following information and ask as many questions as necessary to be sure you understand what you will be asked to do.

Investigator

Kimberly M. French, ASN, BSN, MSN, Georgia Baptist College of Nursing, 3001 Mercer University Drive, Atlanta, GA 30341, 205-451-8770

Purpose of the Research

This research study is designed to explore the experiences of registered nurses, who were employed on a hospital clinical unit or as clinical faculty for at least two years, with incivility during the clinical education of nursing students. This exploration will include the perceptions registered nurses have of incivility in this context, as well as the factors that contribute to this experience. Additionally, the measures used by registered nurses to prevent or disengage from encounters with incivility during the clinical education of nursing students will be investigated. Descriptions of these experiences can aid in the effort to facilitate a resolution of incivility in a clinical education setting.

The data from this research will be used to provide insight into how incivility arises during clinical education and what may be done to resolve it. Therefore, the results will aid in the effort to facilitate the resolution of incivility in a clinical education setting. The researcher will utilize the research findings in future scholarly endeavors, including presentations at professional conferences, publications, and as the basis for further research in this area.

Moreover, the results will contribute to my course of study as a doctoral candidate by allowing the completion of the dissertation requirement of the PhD degree in nursing.

Procedures

If you volunteer to participate in this study, you will be asked to participate in one face-to-face, one-on-one interview session. The session may be completed in a private

meeting room at a local college or in a conference room of a healthcare entity. A telephone interview can be arranged if necessary. The interview will be scheduled at a time that is convenient for both you and me. Questions included in the interview session will focus on your experiences of incivility while employed as a registered nurse during the clinical education of nursing students. The researcher will also ask you to provide demographic information such as your age and gender, highest level of nursing education, years of registered nurse experience, type of nursing unit where incivility took place, length of time employed on the unit where incivility took place, if you have ever served as a clinical educator or preceptor for nursing students and for how long, approximate date of most recent encounter with incivility with a nursing students, and approximate number of encounters with incivility with nursing students during your career.
Your participation will take approximately 60 to 90 minutes of one day of a week.

Potential Risks or Discomforts
There are no foreseeable risks associated with this study. You may encounter negative feelings as you reflect on previous experiences of incivility during the clinical education of nursing students. These feelings may cause discomfort or emotional reactions. You can request to discontinue the interview at any time and dismiss yourself from the study. You may also choose to remove yourself from the interview and rejoin the session at a later time. A referral for counseling services is available upon request and is your sole responsibility. No costs are associated with participating in this study.

Potential Benefits of the Research
There are no foreseeable benefits of participating in this study. However, study findings may benefit future practices in nursing education and within the nursing profession. Further research on incivility during the clinical education of nursing students is likely to result.

Confidentiality and Data Storage
In order to protect the confidentiality of the information you share, the names and exact locations of the healthcare entities will not be specified in this dissertation. To protect confidentiality and promote honest responses regarding incivility during the clinical education of nursing students, your name and the name of your employer will not be utilized. As a participant, your name will not be recorded on any of the transcripts and you will be advised to not mention any identifying information during the interview. Should a name or other identifying information be mentioned, the

information will be removed and random letters will be assigned, such as hospital A or University B. Additionally, the investigator will be writing notes during the interview.

These notes will not contain names of any individuals or additional identifying information mentioned during the interview.

Confidentiality will be protected by your selection of a pseudonym to represent your name on the demographic form. Your pseudonym will be handwritten on the demographic form prior to turning on the two digital recorders. The pseudonym you select will correspond with the pseudonym noted in the transcribed data. Only the principal investigator, transcriptionist, and dissertation chair will have access to digital recordings. The principal investigator and the chair of the dissertation committee will be the only individuals with access to demographic forms. Any names of persons or institutions that may be mentioned during the interview will be redacted and replaced with pseudonyms (for persons) or non-identifying initials (for healthcare entities and educational institutions). The investigator will provide written instructions to the transcriptionist relative to this process to ensure confidentiality of the information you provide as well as the confidentiality of any individuals mentioned by you. Furthermore, the investigator will check all transcribed narratives to ensure confidentiality has been maintained.

A professional transcriptionist will be hired to transcribe the recorded interviews. Transcribed data will be typed in Microsoft Word documents. The researcher will manually code the transcribed narratives and conduct a thematic analysis. Digital recordings will be destroyed at the conclusion of the research process. Original documents will be secured within a locked file box at the investigator's home office for three years, then destroyed. Data must also be stored at Mercer University for at least three years after completion of the study. However, interview transcripts will be kept indefinitely within the investigator's home office and will not contain any identifying information. The results of this study will be utilized by the researcher for future scholarly endeavors. Your identity will never be shared or published.

The investigator will perform weekly back-ups to ensure data are properly saved on an external hard drive. Additional processing methods include data protection through electronic and manual safeguarding measures, including locked storage of external hard drives and documents located within the investigator's home office, maintaining a security code on the investigator's personal laptop, and providing the committee chair

with weekly updates on data processing procedures and copies of transcribed narratives.

Participation and Withdrawal
Your participation in this research study is voluntary. As a participant, you may refuse to participate at any time. To withdraw from the study please contact Kimberly M. French via email: Kimberly.m.french@live.mercer.edu or via telephone: (205) 451-8770. You may also contact the investigator's advisor, Dr. Susan S. Gunby via email: Gunby_SS@mercer.edu or via telephone: (678) 547-6773. Note: Data are anonymous, therefore, subjects cannot withdraw after data collection has taken place.

Questions about the Research
If you have any questions about the research, please speak with Kimberly M. French via email: Kimberly.m.french@live.mercer.edu or via telephone: (205)-451-8770 or with Dr. Susan S. Gunby via email: Gunby_SS@mercer.edu or via telephone: (678)-547-6773.

[Incentives to Participate]
A $25 Target gift card will be given upon completion of the interview.

[Audio or Video Taping]
The interview will be audio recorded for verbatim transcription, therefore, you are consenting to being audio recorded during the one-one-one interviews. Your name and your employer will not be included on the digital recording. If identifiable information is accidentally mentioned during the recording, it will be redacted and replaced during the transcription.

[Reasons for Exclusion from this Study]
You are excluded from this study if you:
(a) are under the age of 18; (b) are unable to read, write, or understand the English language; (c) were employed less than two years as a registered nurse on a hospital clinical unit or as clinical faculty when the experience with incivility occurred.

This project has been reviewed and approved by Mercer University's IRB. If you believe there is any infringement upon your rights as a research subject, you may contact the IRB Chair, at (478) 301-4101.
You have been given the opportunity to ask questions and these have been answered to your satisfaction. Your signature below indicates your voluntary agreement to participate in this research study.

_____	_____
Research Participant Name (Print)	Name of Person Obtaining Consent (Print
_____	_____
Research Participant Signature	Person Obtaining Consent Signature
_____	_____
Date	Date

APPENDIX D

INTERVIEW GUIDE AND DEMOGRAPHIC FORM

Demographic Data Form and Interview Guide

DEMOGRAPHIC INFORMATION

Age: _____ Gender: _____

Highest level of nursing education: _____

Years of registered nurse experience: _____

Type of nursing unit where currently employed: _____

Length of full-time employment on current nursing unit: _____

Have you ever served as a clinical educator or preceptor for nursing students? _____

If so, for how long? _____

Approximate date of most recent uncivil encounter with a nursing student: _____

Approximate number of encounters with incivility with nursing students during career:

_____

SEMI-STRUCTURED INTERVIEW GUIDE

1. Think back over your experience as a registered nurse in a medical-surgical setting and describe an experience with incivility you encountered during the clinical education of nursing students.
    a. How did this experience affect you?
2. What contributing factors led to this encounter?
    a. What attitudes or behaviors did this student exhibit during this act or acts of incivility?
    b. What attitudes or behaviors did you exhibit during this act or acts of incivility?
3. Describe how you attempted to prevent this encounter or to disengage from this encounter.
    a. Have you attended professional development or continuing education courses that provided ways to address incivility? If “yes”, have you used the strategies provided? Why or why not?
    b. How has the *Code of Ethics for Nurses* affected your experiences with nursing students on your clinical unit?
4. What does incivility mean to you?
    a. What other terms come to mind when you think of “incivility”?
5. Describe what perceptions you have about incivility after this experience.

6. Describe a time when you were uncivil toward a nursing student.
    a. What factors contributed to this event?
    b. How was it resolved?
    c. Describe how the uncivil encounter affected you.
    d. What effect did the experience with incivility have on the relationship between the nursing student and you?
7. What effects do you perceive incivility has on the clinical education setting/environment?
    a. What factors contribute to the persistent presence of incivility in the clinical education setting?
8. What effects do you perceive incivility has on the nursing profession?
9. What effects do you perceive incivility has on patient care and patient safety?
10. What factors contribute to stress during the clinical education of nursing students?
11. Describe the organizational conditions that contribute to incivility in the clinical education setting.
12. Describe the current policies your facility has in place to address incivility or other types of disruptive behaviors.
    a. Does your facility have a professional code of conduct?

b. Describe how this code of conduct affects occurrences of incivility in your work environment.

c. What barriers prevent you from abiding by the code of conduct? What facilitates your ability to abide by the code of conduct?

13. Please share any other comments or observations you may have related to the topic of incivility.

APPENDIX E

CONFIDENTIALITY AND DOCUMENT RELEASE FORM

Confidentiality and Document Release

CLIENT NON-DISCLOSURE AGREEMENT

This CLIENT NON-DISCLOSURE AGREEMENT, effective as of the date last set forth below (this "Agreement"), between the undersigned actual or potential client ("Client") and **Rev.com, Inc.** ("Rev.com") is made to confirm the understanding and agreement of the parties hereto with respect to certain proprietary information being provided to Rev.com for the purpose of performing translation, transcription and other document related services (the "Rev.com Services"). In consideration for the mutual agreements contained herein and the other provisions of this Agreement, the parties hereto agree as follows:

1. Scope of Confidential Information

1.1. "Confidential Information" means, subject to the exceptions set forth in Section 1.2 hereof, any documents, video files or other related media or text supplied by Client to Rev.com for the purpose of performing the Rev.com Services.

1.2. Confidential Information does not include information that: (i) was available to Rev.com prior to disclosure of such information by Client and free of any confidentiality obligation in favor of Client known to Rev.com at the time of disclosure; (ii) is made available to Rev.com from a third party not known by Rev.com at the time of such availability to be subject to a confidentiality obligation in favor of Client; (iii) is made available to third parties by Client without restriction on the disclosure of such information; (iv) is or becomes available to the public other than as a result of disclosure by Rev.com prohibited by this Agreement; or (v) is developed independently by Rev.com or Rev.com's directors, officers, members, partners, employees, consultants, contractors, agents, representatives or affiliated entities (collectively, "Associated Persons").

2. Use and Disclosure of Confidential Information

2.1. Rev.com will keep secret and will not disclose to anyone any of the Confidential Information, other than furnishing the Confidential Information to Associated Persons; provided that such Associated Persons are bound by agreements respecting confidential information. Rev.com will not use any of the Confidential Information for any purpose other than performing the Rev.com Services on Client's behalf. Rev.com will use reasonable care and adequate measures to protect the security of the Confidential Information and to attempt to prevent any Confidential Information from being disclosed or otherwise made available to unauthorized persons or used in violation of the foregoing.

2.2. Notwithstanding anything to the contrary herein, Rev.com is free to make, and this Agreement does not restrict, disclosure of any Confidential Information in a judicial, legislative or administrative investigation or proceeding or to a government or other regulatory agency; provided that, if permitted by law, Rev.com provides to Client prior notice of the intended disclosure and permits Client to intervene therein to protect its interests in the Confidential Information, and cooperate and assist Client in seeking to obtain such protection.

3. Certain Rights and Limitations

3.1. All Confidential Information will remain the property of Client.

3.2. This Agreement imposes no obligations on either party to purchase, sell, license, transfer or otherwise transact in any products, services or technology.

4. Termination

4.1. Upon Client's written request, Rev.com agrees to use good faith efforts to return promptly to Client any Confidential Information that is in writing and in the possession of Rev.com and to certify the return or destruction of all Confidential Information; provided that Rev.com may retain a summary description of Confidential Information for archival purposes.

4.2. The rights and obligations of the parties hereto contained in Sections 2 (Use and Disclosure of Confidential Information) (subject to Section 2.1), 3 (Certain Rights and Limitations), 4 (Termination), and 5 (Miscellaneous) will survive the return of any tangible embodiments of Confidential Information and any termination of this Agreement.

5. Miscellaneous

5.1. Client and Rev.com are independent contractors and will so represent themselves in all regards. Nothing in this Agreement will be construed to make either party the agent or legal representative of the other or to make the parties partners or joint venturers, and neither party may bind the other in any way. This Agreement will be governed by and construed in accordance with the laws of the State of California governing such agreements, without regard to conflicts-of-law principles. The sole and exclusive jurisdiction and venue for any litigation arising out of this Agreement shall be an appropriate federal or state court located in the State of California, and the parties agree not to raise, and waive, any objections or defenses based upon venue or forum non

conveniens. This Agreement (together with any agreement for the Rev.com Services) contains the complete and exclusive agreement of the parties with respect to the subject matter hereof and supersedes all prior agreements and understandings with respect thereto, whether written or oral, express or implied. If any provision of this Agreement is held invalid, illegal or unenforceable by a court of competent jurisdiction, such will not affect any other provision of this Agreement, which will remain in full force and effect. No amendment or alteration of the terms of this Agreement will be effective unless made in writing and executed by both parties hereto. A failure or delay in exercising any right in respect to this Agreement will not be presumed to operate as a waiver, and a single or partial exercise of any right will not be presumed to preclude any subsequent or further exercise of that right or the exercise of any other right. Any modification or waiver of any provision of this Agreement will not be effective unless made in writing. Any such waiver will be effective only in the specific instance and for the purpose given.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed below by their duly authorized signatories.

CLIENT

Print Name: Kimberly M French

By: Kimberly M French
Name: Kimberly M. French
Title: Principal Investigator
Date: 6/26/17

Address for notices to Client:

201 West Mall
Trussville, AL 35173

REV.COM, INC.

By: Cheryl Brown
Name: Cheryl Brown
Title: Account Manager
Date: April 7, 2017

Address for notices to Rev.com, Inc.:

251 Kearny St. FL 8
San Francisco, CA 94108

APPENDIX F

INVITATIONAL EMAIL

Invitational Email

Greetings,

My name is Kimberly French and I am a PhD student in the Georgia Baptist College of Nursing at Mercer University. I am seeking registered nurses to be participants in my dissertation research. The dissertation is entitled *Experiences of Registered Nurses Who Encounter Incivility During the Clinical Education of Nursing Students: A Phenomenological Analysis*. The focus of this research is on the experiences of staff nurses who have experienced incivility with nursing students during clinical education.

Please contact me if you are interested in being a potential participant in my study and if you meet these inclusion criteria:
(a) Have had an uncivil encounter during your nursing career with at least one nursing student, who was present on a hospital clinical unit to receive clinical education;
(b) At the time of the uncivil encounter, you were employed on a hospital clinical unit or as clinical faculty for a minimum of 2 years at the time of the uncivil encounter.

A flyer is attached with additional information.

Should you have any questions regarding this research you may contact me, or you may talk with the Chair of my dissertation committee, Dr. Susan S. Gunby (678-547-6773). My contact information is listed below and on the flyer as well.

Thank you for your time. I sincerely appreciate your consideration of my request to be a part of my dissertation research.

Thank you!

Kimberly French
205-451-8770
Kimberly.m.french@live.mercer.edu

APPENDIX G

PERMISSION TO USE CLARK AND COLLEAGUES' (2011) CONCEPTUAL MODEL

Dear Kimberly, “As requested, I am granting permission to use my Conceptual Model for Fostering Civility in Nursing Education (Adapted for Practice). I have attached it to this e-mail; it requires full citation/referencing which is contained on the model. I wish you well with your studies.”

Cindy Clark

This letter of permission was sent via email from Dr. Cynthia Clark and received by me on October 17, 2016.

APPENDIX H

MERCER UNIVERSITY INSTITUTIONAL REVIEW BOARD APPLICATION APPROVAL LETTER

MERCER UNIVERSITY

Institutional Review Board
For Research Involving Human Subjects

Tuesday, June 20, 2017

Ms. Kimberly M .French
3001Mercer University Drive
Georgia Baptist College of Nursing
3001Mercer University Drive
Atlanta, GA 30341

RE: Experiences of Registered Nurses Who Encounter Incivility During the Clinical Education of Nursing Students in an Acute Care Setting:A Phenomenological Analysis (H1706170)

Dear Ms. French:

On behalf of Mercer University's Institutional Review Board for Human Subjects Research, your application submitted on 15-Jun-2017 for the above referenced protocol was reviewed in accordance with Federal Regulations 21 CFR 56.110(b) and 45 CFR 46.110(b)(for expedited review) and was approved under category(les) 6,7 per 63 FR 60364.

Your application was approved for one year of study on 20-Jun-2017. The protocol expires on 19-Jun-2018. If the study continues beyond one year, it must be re-evaluated by the IRB Committee.

Item(s) Approved:
A qualitative approach using descriptive phenomenology will be used to address the research question: What experiences with incivility have registered nurses, working as staff nurses in acute care settings, encountered during the clinical education of nursing students?

NOTE: Please report to the committee when the protocol is initiated. Report to the Committee Immediately any changes in the protocol or consent form and ALL accidents, injuries, and serious or unexpected adverse events that occur to your subjects as a result of this study.

We at the IRB and the Office of Research Compliance are dedicated to providing the best service to our research community. As one of our investigators, we value your feedback and ask that you please take a moment to complete our Satisfaction Survey and help us to improve the quality of our service.

It has been a pleasure working with you and we wish you much success with your project! If you need any further assistance, please feel free to contact our office.

Respectfully,

Ava Chambliss-Richardson, Ph.D. ,CIP, CIM.
Associate Director of Human Research Protection Programs (HRPP)
Member
Institutional Review Board

"Mercer University has adopted and agrees to conduct Its clinical research studies in accordance with the International Conference on Harmonization's (ICH) Guidelines for Good Clinical Practice."